



**Maternal and Child Health Services
Title V Block Grant**

**State Narrative for
Georgia**

**Application for 2011
Annual Report for 2009**



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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.

An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Georgia's assurances and certifications are available on file in the state's Title V agency, the Department of Community Health, Division of Public Health's Maternal and Child Health Program located on the 11th floor of 2 Peachtree Street, Atlanta, Georgia 30303. For further information, please contact the MCH Program Director's Office at 404/657-2851.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

The MCH Program has made a significant commitment to ensuring adequate and varied public comment opportunities. As part of Georgia's 2010 Needs Assessment process, efforts were made to ensure a mix of parents/consumers and health care providers in the community. Outreach efforts to the Hispanic population in Georgia communities were deployed, and as a result, several focus groups were conducted in Spanish. Additional focus groups were conducted to ensure involvement of MCH internal stakeholders in District Health Offices through the use of VICS, the two-way video-conferencing system operated by the Georgia Department of Community Health. A total of 182 Georgia citizens were engaged through 15 needs assessment community focus groups. A day-long focus group that included 45 non-governmental maternal and child health providers and advocacy groups from throughout Georgia provided an additional opportunity for public comment. The input received through these focus groups was used to identify a comprehensive list of needs in the MCH community in Georgia.

Following the focus groups, 55 needs were identified from which the top ten priority needs in Georgia were to be selected. Public input was sought in the selection of these needs. A web-based survey sent to all Division of Public Health employees was conducted to ensure that all staff had an opportunity to identify the needs they believed to be of greatest priority among the 55 needs identified previously. There were 311 responses from staff throughout Georgia. A meeting was held that included more than 50 participants representing advocacy groups, academia, local MCH staff, other HRSA grantees, and parents of children with special health care needs to evaluate each need on several dimensions. Participants were divided into several tables where they shared their individual expertise and discussed each need prior to each participant completing an individual assessment.

Following the selection of the top ten priority needs, the completion of the quantitative and qualitative data report, and the activity plan for FY11, these three documents were posted on a dedicated web page where each document could be downloaded and/or reviewed for public

comments submitted. All focus group participants who provided an email address, district health directors, advocacy groups, Georgia's AMCHP CSHCN family delegate, non-governmental agencies, and Division of Public Health program directors received an email from the Title V MCH Director with a link to the public comment web page and a request for their input and for them to forward the link as broadly as possible. The initial email was sent to more than 250 people throughout Georgia. The comment period lasted from June 10, 2010 through June 24, 2010. There were 537 unique page views. Forty-three comments were entered, of which nine were from parents or family members of children with special health care needs. Overall, the comments were supportive and complementary of the FY11 activity plan, top priority needs, the detail and presentation of the assembled data, and the process for engaging partners and developing the documents. The comments also identified some key areas of concerns that, if addressed, could help to improve the health status of the MCH population throughout Georgia. All submitted comments are included in the attachment. Comments have been shared with leadership in the Division of Public Health and MCH Program.

Following the submission and review of the FY11 application, the final document will be posted on the MCH Program website (<http://health.state.ga.us/programs/family>), and one copy will be distributed to each public health district director, all MCH Program staff, and all Division of Public Health Leadership. The quantitative and qualitative data will be developed into a report on the state of women, infants, and children in Georgia with a formal release to MCH partners, stakeholders, and the media.

An attachment is included in this section.

II. Needs Assessment

In application year 2011, the 2010 Needs Assessment will be attached to this Section II.

An attachment is included in this section.

C. Needs Assessment Summary

In 2010, as part of the FY11 Title V MCH Services Block Grant application, Georgia Title V in the MCH Program concluded its five-year needs assessment process. An emphasis of the qualitative data collection strategy was the engagement of a diverse community of MCH and CSHCN stakeholders statewide. Community-based focus groups were arranged and conducted in various locations in the state through a partnership effort of the MCH Program and the public health districts. Efforts were made to ensure a mix of parents/consumers and health care providers in the community. A positive response to outreach efforts to the Hispanic population in Georgia communities resulted in several focus groups conducted in Spanish. Additional focus groups were conducted to ensure involvement of MCH internal stakeholders in Georgia's 18 public health districts through the use of VICS, the two-way video-conferencing system operated by the Georgia Department of Community Health.

A total of 182 Georgia citizens were engaged through 16 needs assessment community focus groups. Thirty percent of the participants indicated that they their primary source of health coverage was Medicaid and nearly 85 percent (n=154) were women. Parents of a child with special health care needs (n=78) and providers (n=65) were the most common characteristics among participants. More than half of all participants (n=98) were of a race/ethnicity other than White.

The qualitative data were supplemented with analyses from approximately 15 different data sources. Analyses included all national performance measures and outcome measures in additional to other indicators of interest. Where possible, data were stratified by age, race/ethnicity, maternal educational attainment, and/or sex; and maps were included that displayed point estimates for each of the public health districts.

The qualitative and quantitative data analyzed produced 55 needs to be considered for selection as Georgia's top priority needs. Through a series of surveys and meetings, the following nine needs were selected as the top priority needs for Georgia:

- (1) Decrease infant mortality and injury
- (2) Reduce motor vehicle crash mortality among children ages 15 to 17 years
- (3) Decrease obesity among children and adolescents
- (4) Reduce repeat adolescent pregnancy
- (5) Increase developmental screening for children in need
- (6) Improve the maternal and child health surveillance and evaluation infrastructure
- (7) Improve childhood nutrition
- (8) Increase awareness of the need for preconception health care among women of childbearing age

(9) Increase the number of qualified medical providers who accept Medicaid and who serve children with special health care needs

Except for reducing repeat adolescent pregnancy, which was incorporated into the activity plan for National Performance Measure 8, all other priority needs are directly addressed by one or more of the state performance measures for the 2011 through 2015 Title V MCH Services Block Grant cycle.

In the 2010 Needs Assessment, many of the priority needs selected are within the broad topic areas identified in the 2005 Needs Assessment but are more specific. When comparing the priority needs from 2005 to the priority needs from 2010, with the exception of one priority need, all priority needs in 2010 are related to priority needs selected in 2005. While not explicitly stated in the priority needs for 2010, all priority needs in 2010 are expected to reduce health disparities among MCH populations and utilize partnerships to improve outcomes; two needs explicitly identified in 2005.

Reduce unintentional and intentional injury was a priority need identified in the 2005 Needs Assessment. Among the priority needs selected in the 2010 Needs Assessment related needs were decrease infant mortality and injury and reduce motor vehicle crash mortality among children ages 15 to 17 years.

Promote health nutritional behaviors and physical activity among the MCH population was a priority need identified in the 2005 Needs Assessment. Among the priority needs selected in the 2010 Needs Assessment related needs were decrease obesity among children, adolescents and reduce repeat adolescent pregnancy, and improve childhood nutrition.

Assure a comprehensive system of age appropriate screening, referral, and follow-up for children from birth through age 21 years was a priority need identified in the 2005 Needs Assessment. Among the priority needs selected in the 2010 Needs Assessment a related need was to increase developmental screening for children in need.

Assure an adequate MCH workforce was a priority need identified in the 2005 Needs Assessment. Among priority needs selected in the 2010 Needs Assessment a related need was to improve the maternal and child health surveillance and evaluation infrastructure.

Promote preconception health was a priority need identified in the 2005 Needs Assessment. Among priority needs selected in the 2010 Needs Assessment a related need was to increase awareness of the need for preconception health care among women of childbearing age.

In the 2010 Needs Assessment, the priority need to increase the number of qualified medical providers who accept Medicaid and who serve children with special health care needs was not similar to any of the priority needs identified in the 2005 Needs Assessment.

Two priority needs identified in 2005 are not addressed in the priority need identified in 2010. These are:

- (1) assure early access to prenatal and postpartum care for pregnant women
- (2) improve oral health

While two priority needs from 2005 are not included in the 2010 priority needs, each of these needs is addressed, at least partially, through national performance measures. National Performance Measure 18 addresses early entry into prenatal care. National Performance Measure 9 addresses oral health by measuring the percent of children in third grade who have dental sealants on at least one molar.

III. State Overview

A. Overview

ADMINISTRATIVE STRUCTURE AND FUNCTIONS

****Georgia Title V****

The purpose of Georgia Title V is to address the overall intent of the Maternal and Child Health Services Block Grant to improve the health of all mothers, women of childbearing age, infants, children, adolescents and children with special health care needs (CSHCN). The state of Georgia has responsibility to provide and assure access to quality MCH services for mothers and children; provide and promote family-centered, community-based, coordinated systems of care for CSHCN and their families; and facilitate the development of community-based systems of care for the MCH and CSHCN populations. The Georgia Title V Program is located within the MCH Program.

****Georgia Maternal and Child Health Program****

The Director of the MCH Program also serves as the Title V MCH Services Block Grant MCH Director. In addition to the Georgia Title V Program, the MCH Program also includes the Georgia Family Planning Program (Title X and XX); Babies Can't Wait Program (Part C Early Intervention); newborn hearing and metabolic/genetic screening follow-up and referral; the Special Supplemental Program for Women, Infants, and Children; MCH epidemiology; Children 1st Program; Oral Health Program; and other grant-funded and quality assurance work that includes the State Systems Development Initiative, Early Childhood Comprehensive Systems Grant, and the Health Check Program. Each of these programs is described in detail on the MCH Program website (<http://health.state.ga.us/programs/family/>). Within the context of the MCH Program, Georgia Title V is a driver for integration across programs, within and beyond the MCH Program, and, with all Title V-associated performance measures either explicitly or implicitly required among all other MCH programs, the Title V application and annual activity plan serves as the cornerstone of MCH Program strategic activities. The organizational structure and scope of the MCH Program is undergoing review. Organizational and structural changes may be proposed to increase staff accountability, facilitate staff professional growth that supports the engagement of key stakeholders and partners, implement evidence-based programming, and deliver excellent customer service.

In March 2010, the MCH Program implemented new mission and vision statements.

Mission Statement: To implement measurable and accountable services and programs to improve the health of women, infants, children, fathers, and families throughout Georgia.

Vision Statement: Through the implementation of evidence-based strategies, maximization of resources through integration and collaboration, and the use of program and surveillance data, identify and deliver public health information, population-based interventions, and direct services that have an impact on the health status of women, infants, children, fathers, and families throughout Georgia.

The primary change from previous mission and vision statements and the primary driver for the development of these new statements was to increase the focus on measurement and accountability. Integral to the success of the MCH Program is the implementation of a data to action culture founded on strong measurement and accountability principles. The MCH Program is committed to creating synergy between research and practice by advancing data-driven decision making and strategic planning through the collection, analysis, and interpretation of state and national data to identify trends and challenges that can be addressed through identified best practices or innovative practice solutions. This data to action approach drives all MCH Programs including Georgia Title V.

The current mission and vision statements for the MCH Program are supported by five programmatic goals.

Goal 1: Ensure compliance and operational excellence for all federally and state funded activities.

Ensuring compliance and operational excellence will be achieved through the timely submission of all required products; development and implementation of a quarterly performance measure process track and react to program developments; conducting a review of current MCHP organizational structure and making necessary changes; and ensuring programmatic accountability. Achieving success for Goal 1 also requires the development of annual activity plans that are integrated across programs that have clear expected outcomes and are monitored routinely for progress.

Goal 2: Increase the evidence-base for decision making through improved data collection at the state, district, and county level.

Increasing the evidence-base is directly related to increasing the surveillance, evaluation, and MCH epidemiology capacity of the MCH Program. This coincides with infrastructure building activities in the Title V Services Pyramid. For Goal 2, evidence-base is broadly understood to mean implementing best practices, appropriate and thorough programmatic data collection, expanded surveillance, supported MCH research that can inform program development, and the distribution of research and data findings in a manner that is easily consumable by all stakeholders and partners.

Goal 3: Increase population-based services and infrastructure building.

The MCH Program will work to identify training needs that, if addressed, would benefit the entire MCH community. Increased public health media messages are of immediate interest in response to Goal 3.

Goal 4: Ensure improved integration within and between the Maternal and Child Health Program and other Division of Public Health (DPH) Programs.

Ensuring improved collaboration and integration within the MCH Program and between programs within the Division of Public Health is necessary to accomplish MCH Program objectives, ensure efficient and effective program operation, and maximize the resources and benefits available to Georgia's women, infants, children, youth, fathers, and families. The MCH Program must work with its internal partners to ensure that client contacts are leveraged to achieve the programmatic objectives of all applicable programs. Several of the activities planned for the national and state performance measures in FY11 support this goal.

Goal 5: Provide statewide leadership in the MCH community.

Providing state leadership in the MCH community as well as engaging family partners in all aspects of decision-making will help provide vision and direction for collaborative projects between MCHP and other programs and the MCH community. The MCH Program made significant progress in reaching this goal while developing its response to this application. In preparing for the FY11 application, the MCH Program made documents available prior to the completion of the application for comment and edits; conducted sixteen focus groups to gather information from consumers, stakeholders, advocates, and partners; and engaged consumers, stakeholders, advocates, and partners in the selection of the state's priority needs. At all opportunities for public input and participation, enhanced efforts were made to ensure the involvement of families with children with special healthcare needs. While much of this activity was driven by the development of the needs assessment, it is the responsibility of the MCH Program to ensure that there are opportunities for public, stakeholder, and advocate comment,

input, and involvement in the annual Title V application process and the operation of all MCH Programs.

****Division of Public Health****

The Division of Public Health includes the MCH Program and six other programs.

Health Promotion and Disease Prevention

Epidemiology

State Laboratory

Immunization and Infectious Disease

Environmental Health

Vital Records

Each of these programs works with the MCH Program to accomplish joint goals and enhance the health of MCH populations throughout Georgia. A brief description of each program follows.

The mission of the Health Promotion Disease Prevention (HPDP) Program is to encourage Georgians to improve the quality of their lives by achieving healthy lifestyles, creating healthful environments, and preventing chronic disease, disability, and premature death. The HPDP Program includes Asthma Control Program, Adolescent Health and Youth Development Program, Comprehensive Cancer Control Program, Breast and Cervical Cancer Program, Tobacco Use Prevention Program, Rape Prevention and Education Program, the Nutrition and Physical Activity Initiative, and several others. A complete listing of the all programs within the HPDP Program can be found at <http://health.state.ga.us/programs/chronic/index.asp>. The HPDP Program collaborates with the MCH Program to address National Performance Measures 8 and 15 and State Performance Measure 1.

The Epidemiology Program is responsible for acute disease, chronic disease, injury, and environmental epidemiology. The Epidemiology Program is responsible for the administration of the Georgia Behavioral Risk Factor Surveillance System and the Youth Risk Behavior Surveillance System. The Office of Health Indicators for Planning is located within the Epidemiology Program and provides access to several data sets that include MCH indicators through the Online Analytical Statistical Information System (OASIS). OASIS is used to query data sets and population projections needed to report on measures required as part of the Title V MCH Services Block Grant application.

The mission of the State Laboratory Program is to improve the health status of Georgians by providing accurate, timely and confidential clinical and non-clinical laboratory testing in support of Division of Public Health programs, activities, and initiatives as well as performing tests for Emergency Preparedness. The State Laboratory processes all state mandated newborn metabolic/genetic screening tests. The State Laboratory works closely with the MCH Program to complete Form 6 and address National Performance Measure 1.

Through collaboration with public and private providers, advocacy groups, and other stakeholders, the mission of the Infectious Disease and Immunization (IDI) Program is to work to increase immunization rates for all Georgians and decrease the incidence of vaccine-preventable diseases. Vaccine-preventable disease levels are at or near record lows. Even though most infants and toddlers have received all recommended vaccines by age 2, many under-immunized children remain, leaving the potential for outbreaks of disease. Many adolescents and adults are under-immunized as well, missing opportunities to protect themselves against diseases such as Hepatitis B, influenza, and pneumococcal disease. Strong collaboration is needed with IDI Program to address National Performance Measure 7.

The mission of the Environmental Health Program is to provide primary prevention through a combination of surveillance, education, enforcement, and assessment programs designed to

identify, prevent and abate the environmental conditions that adversely impact human health.

The mission of the State Office of Vital Records is to provide accurate records and data concerning vital events to Georgians and other stakeholders in an expeditious and friendly manner. Many of the reportable measures required as part of the Title V MCH Services Block Grant application could not be reported without the data provided by the State Office of Vital Records.

****Department of Community Health****

The Division of Public Health is located in the Department of Community Health (DCH). The mission of DCH is:

- Access to affordable, quality health care in our communities
- Responsible health planning and use of health care resources
- Healthy behaviors and improved health outcomes

The vision of DCH is to be a results-oriented, innovative, and productive state agency that seeks to address the health care needs of all Georgians by serving as a national leader in the areas of health planning, health promotion, and health care quality by the year 2011. The DCH mission and vision statements are consistent with the Georgia Title V Program. In addition to the Division of Public Health, DCH includes nine divisions and six offices. A brief description of each follows.

Emergency Preparedness and Response Division works to ensure a safe and healthy environment for all Georgians. The Emergency Preparedness and Response Division includes the Injury Prevention Program. The mission of the Injury Prevention Program is to prevent injuries by empowering state and local coalitions through the provision of data, training, and leadership, and the leveraging of resources for prevention programs. The Injury Prevention Program is responsible for the Child Occupant Safety Interventions and Education Program and Residential Fire Prevention Program. Through collaboration with the MCH Program, the Injury Prevention Program works to address National Performance Measures 10 and 16 and State Performance Measures 2 and 4.

The Division of Financial Management represents the financial interests of the Department. It is comprised of the Office of Planning and Fiscal Analyses, Financial and Accounting Services, Reimbursement Services and the Budget Office.

The General Counsel Division provides overall guidance and direction for the operations of the Division; drafts and reviews procurement documents; provides legal services for all aspects of the State Health Benefit Plans; develops policies and procedures for compliance with federal and state privacy and public records requirements; drafts rules, regulations and policies for consideration by the Board of Community Health; and provides staff support for the Health Planning Review Board. Also contains the Certificate of Need Section and Division of Health Planning.

Healthcare Facility Regulation is responsible for protecting the residents of Georgia by ensuring the highest quality of health care and safety through professional standards regulation.

Information Technology is responsible for promoting project management standards throughout DCH. The Medicaid Management Information System (MMIS) unit supports the various systems used for the processing, collecting, analyzing and reporting of information needed to support all Medicaid and PeachCare for Kids claim payment functions

The Office of Inspector General is responsible for DCH's efforts to detect, prevent and investigate fraud and abuse in Medicaid, PeachCare for Kids™ and the State Health Benefit Plan.

The Division of Medical Assistance Plans administers the Medicaid program, which provides health care for children, pregnant women, and people who are aging, blind and disabled.

The Operations Division consists of the Office of Vendor and Grant Management, Human Resources, Support Services, the Office of Health Policy and Strategy, and the Department's five Health Improvement Programs, which are the Office of Minority Health, the Office of Women's Health, the Georgia Commission on Men's Health, the Georgia Volunteers in Health Care program and the State Office of Rural Health.

The State Health Benefit Plan (SHBP) provides health insurance coverage to state employees, school system employees, retirees and their dependents. The Georgia Department of Community Health's Public Employee Health Benefits Division is responsible for day-to-day operations.

SOCIODEMOGRAPHIC FACTORS IN GEORGIA

The success of the state's and the Title V Program's efforts to craft and implement a strategic direction depends on an ability to predict, understand, and develop strategies around factors that impact the health and well-being of women and children in the context of their communities. The following information provides an overview of some of the characteristics of Georgia that potentially may have the most significant impacts on the maternal and child health populations.

****Geography and Urbanization****

Georgia's land mass (59,425 square miles) makes it the largest state east of the Mississippi River and the 24th largest in the United States (U.S.). Since 1990, Georgia's population has increased over 50%, moving it from the 11th to the 9th largest state in the nation. The state's growth comes from a combination of natural increase (i.e., births versus deaths) and domestic and international migration. The explosive increase experienced by the "Sunbelt" states, including Georgia, through most of this decade, slowed dramatically with the onset of the economic recession beginning in late 2007. Nevertheless, from July 2000 to July 2009, the state's population increased by 1.6 million, reaching a total population of 9,829,211. While the rate of population growth has slowed, Georgia has remained among the fastest growing states in the nation, exceeded only by Texas, California, and North Carolina. Georgia was 4th largest in terms of new residents and 9th largest in terms of percent gain. The result of this fundamental shift in Georgia's population has changed the state from a largely rural area with urban clusters to an urban state with rural areas.

****Population****

While population is a significant consideration in service and delivery planning, the political framework is also an important factor. With 159 counties, Georgia has the second highest number of any state. Four of these counties, all in the Atlanta MSA, have populations in excess of 700,000 (Fulton, Cobb, DeKalb and Gwinnett) with no other county in the state exceeding a population of 276,000. In addition to these four, there are 18 counties having populations of over 100,000, with 10 of these 18 counties located in the Atlanta MSA. The remaining 137 counties have fewer than 100,000 population with 87 of them having populations of less than 25,000 and 30 counties with a population of fewer than 10,000.

Census data highlight the exceptional growth and increasing diversity of Georgia. Adding to the already large number of Blacks residing in Georgia has been a steady stream of Black people moving to the state. Georgia ranks 3rd nationally, behind New York and Florida, in the number of Black people (2,864,431) and 3rd in the percentage of Black people (30.1%) in the overall population of the state, trailing Mississippi and Louisiana.

Reflecting national trends, the number of Asian people and Hispanic people in Georgia have shown dramatic increases, which are projected to continue. Hispanic people, primarily Mexican

people, are the most rapidly growing minority group (729,604) and now reside throughout Georgia. This growth impacts the provision of government and health, education, and human services in the state. Of individuals five years of age or older living in Georgia in 2006 through 2008, 12% spoke a language other than English at home.

According to the US Census Bureau, Georgia's population continues to be younger compared to the U.S. as a whole, ranking 5th in terms of the percentage with the largest population under 18 years old. In 2008, of the state's population, 740,521 (29.2%) were under the age of five years, with another 2,075,140 million children school-age (five through nineteen years of age). In 2008, women accounted for 50.8% of Georgia's residents. Of all women in Georgia, 42.0% are considered to be of childbearing age (15 to 44 years of age). Annually, there are approximately 150,000 resident births in Georgia. Of all children 17 years of age and younger in Georgia, 352,567 (13.9%) have special health care needs.

****Poverty****

Georgia's per capita income has been lower than the national average since 1997. However, the lower per capita income, a measure of well-being, has been offset until recently by the state's cost of living which has remained relatively low, enabling Georgia residents to do more with the income they do earn. Reflecting the economic downturn, the state's per capita personal income decreased from \$34,612 in 2008 to \$33,786 in 2009, which ranks 39th among all states.

According to the National Center for Children in Poverty (NCCP), of Georgia's 1,402,694 families, with 2,484,182 children, 42% of these children lived in low-income (income below twice the FPL) families in 2008. In particular, young children (birth to age five) are likely to live in low-income families. Twenty-six (26%) of Georgia's young children (birth to age five) live in a low-income family with income less than 100% of FPL, 22% live in families with incomes 100-200% of FPL, and 52% live above low income in 2008. Fifty-eight percent (58%) of the young children in low-income families lived with a single parent. Children living in minority families and children of foreign-born parents have a greater chance of living in a low-income family. Thirty percent (30%) of young white children lived in a low-income family in 2008 compared to 64% of young black children and 71% of young Hispanic children.

Despite noted success in enrolling children into Georgia's Medicaid and PeachCare for Kids (State Child Health Insurance Program) programs, 282,247 (10.9%) children are uninsured in Georgia. The vast majority of these children (86.2%) come from families where at least one parent works and over half (55.4%) live in two-parent households. Almost three-quarters of the uninsured children live in families with low or moderate incomes, less than \$40,000 for a family of four, an income within the current Medicaid and PeachCare eligibility range.

Georgia continues to experience declining employment. In March 2010, Georgia had 3,807,500 jobs, down 3% (116,000 jobs) from March 2009. The state's March 2010 unemployment rate was a record 10.6%. Reflecting the high unemployment rate, Georgia has the 7th highest foreclosure rate. Despite the continued rise in the state's unemployment rate, there are signs of improvement. The pace of new layoffs is slowing significantly, first-time claims for unemployment insurance decreased 28% from a year earlier; and modest job growth has been seen over two consecutive months (February and March 2010), suggesting that the worst of the recession may be over and the state's fledgling recovery may be gaining traction.

GEORGIA'S HEALTH CARE SYSTEM

Georgia's health system consists of five interconnected components: private providers, hospitals, community health clinics, regional behavioral health and developmental disabilities services, and the state's public health system which has two separate elements, the Medicaid/PeachCare payment system and county public health services. Service delivery in the state's public health system is carried out by 159 county boards of health. These boards of health are combined into

18 district units, ranging from one to 16 counties in size, and are administratively overseen by a district office that provides management services and programmatic support. The county boards of health provide direct health care services, environmental health activities, and work with community partners in their county around issues of common concern.

****Private Providers****

The Georgia Department of Labor (DOL) employment projections to 2012 indicate that healthcare and social assistance employment is expected to grow the fastest of all industry sectors in the state, with an annual rate of 3.2% and the addition of more than 125,000 new jobs. Eight of the 20 fastest growing occupations are in the health services industry. DOL projects a growth rate of 5.4% for medical assistants, 5.1% for dental hygienists, 4.9% in dental assistants, 4.8% in physician assistants and in medical records and health information technicians, 4.3% in home health aides, 4.1% respiratory therapists, and 3.6% in surgical technologists. Registered nurses (RN), the largest of all healthcare occupations is the occupation with the second most expected job growth, with a projection of 19,880 newly created RN positions.

Georgia faces challenges in meeting the demand for healthcare occupations. The Georgia Board for Physician Workforce, the state agency responsible for advising the Governor and General Assembly on physician workforce and medical policy and issues concluded in 2006 that growth in medical specialties was minimal or negative; there were substantial problems in geographic distribution of primary care physicians, pediatricians, and obstetricians/gynecologists; and the state will require new physicians just to maintain current capacity.

A 2007 State Senate Study Committee report on the shortage of doctors and nurses in Georgia also concluded that the state is facing a severe shortage of physicians and nurses. Data gathered by the American Medical Association (AMA) supports this conclusion. The AMA found that Georgia ranked 40th in the nation in per capita number of practicing physicians and 42nd in its per capita supply of registered nurses. Georgia ranks 34th in the number of medical students per capita and 37th in medical residents per 100,000 population.

The Senate Committee also recommended that medical school enrollment in Georgia be increased. A 2008 medical education study on behalf of the University System of Georgia of the Georgia Board of Regents is serving as a road map for statewide expansion of Georgia's public medical education system. A partnership is being developed between the Medical College of Georgia (MCG), the state's only public university devoted exclusively to health sciences, and the University of Georgia (UGA), the leading public research university. With full implementation of the plan, through its partnership with UGA, MCG School of Medicine could expand from its current level of 745 students to 1,200 by 2020, an increase of approximately 60% in medical students.

As of July 2009, there were 101,762 registered nurses (RNs) licensed in Georgia; however, not all of these RNs were practicing full-time. Some were retired, but maintained their licensure; others were working only part-time as a nurse or were employed in a nearby state. Several federal labor sources suggest that only approximately 65,000 of the nurses licensed in Georgia in 2009 were working full-time. Georgia consistently ranks in the bottom ten states in terms of the number of RNs per population (670/100,000 in 2008).

Despite the recession, nursing employment rates have remained relatively steady in Georgia and the U.S. as a whole, and there are still more jobs than there are nurses. A shortfall of an estimated 16,400 registered nurses in Georgia in 2010 is expected to grow to 37,700 by 2020. One impact in Georgia's economic downturn has been an increase in the number of former part-time nurses who are returning to the workforce as full-time workers, as well older nurses who are delaying plans to retire. This has expanded the pool of experienced nurses in the workforce.

In response to the Senate Committee recommendation to increase nursing school enrollment, the

state University System, Technical College System, and private institutions have been working to address the state's shortage of RNs. In 2008, the University System and Technical College System graduated 2,231 new pre-licensure nurses, approximately 1,000 more graduates than in 2002. This gain reflects an increase in the number of nursing programs operated by the Technical College System. In addition, approximately 300 RNs graduated from private nursing institutions as part of the 2007-2009 academic year.

Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas (MUAs):

Health Professional Shortage Areas (HPSAs) are designated by the federal Health Resources and Services Administration (HRSA) as having shortages of primary medical care, dental or mental health providers and may be geographic (a county or service area), demographic (low income population) or institutional (comprehensive health center, federally qualified health center or other public facility). Medically Underserved Areas/Populations are areas or populations designated by HRSA as having too few primary care providers, high infant mortality, high poverty and/or high elderly population. Georgia has 125 Mental Health Professional Shortage Areas (MPHSAs), 136 Primary Health Professional Shortage Areas (HPSAs), and 94 Dental Health Professional Shortage Areas.

Georgia Statewide Area Health Education Center (AHEC) Network: The Georgia Statewide AHEC Network is a partnership between the Medical College of Georgia and Mercer University School of Medicine. The Statewide AHEC Network has represented a growing partnership of health providers, health professions, educators, state agencies, and communities joined together to respond to the problems of health professional supply and distribution in rural and underserved areas of the state.

The state's six AHECs work with secondary youth, college and technical college students, displaced workers, older adults, and second career seekers. Programs include general health careers recruitment presentations, health career fairs, and a wide range of video, manual and classroom resources. In addition, intensive programs include health career camps and clubs, as well as academies designed for middle and high school math and science teachers. In 2009, the AHEC network served 48,562 health careers participants and over 150,662 participated between 2007 and 2009. Only 11 of the state's 159 counties did not have an AHEC sponsored health careers recruitment or education program.

The AHEC Network also provides assistance and support for health professions students completing community-based clinical training, including identification and credentialing of training sites, faculty development of community-based preceptors, providing student orientation to the community, providing student travel, and/or housing support during rotations, and conducting site visits. Over 11,160 health professions completed community-based clinical rotations supported by one of the six regional AHEC centers between 2007 and 2009, including 3,893 in 2009. The 11,160 health professionals included 3,035 physicians, 1,601 physician assistants, 656 nurse practitioners, 1,706 nurses, and 4,169 "other."

The Statewide AHEC Network also works to retain health care providers in the workforce. Professional isolation in rural areas of the state is addressed by connecting community-based providers to academic institutions as well as providing relevant and accessible continuing education opportunities for all levels of providers. Between 2007 and 2009, 32,882 AHEC participants completed AHEC sponsored continuing education courses. Participants came from all 159 Georgia counties with 9,071 completing continuing education courses in 2009.

****Hospital System****

There are approximately 200 hospitals in Georgia, including 149 acute care facilities. There is at least one hospital located in 111 of the state's 159 counties. According to a 2008 American Hospital Association survey, the state's hospitals employed more than 138,000 persons;

delivered 142,000 babies yearly; provided 959,000 inpatient admissions, 3.8 million emergency room visits, and 10.3 million other outpatient visits; and had an average daily census totaling almost 17,000.

Trauma Centers: One critical aspect of the hospital-based delivery system is the availability of trauma and emergency care. Georgia, which does not have a statewide trauma system, has 15 Trauma Centers. The state's Trauma Centers are ranked as Levels 1, 2, 3, or 4. A Level 1 Trauma Center is the most comprehensive and has a full spectrum of capacity with surgical subspecialties and a clinical research programs. Most of Georgia's Level 1 Trauma Centers are academic facilities. Like a Level 1, a Level 2 Trauma Center has a full spectrum of capacity with surgical subspecialties, but is not required to have a clinical research program. A Level 3 Trauma Center is a community hospital with general surgical, orthopedic, and anesthetic capacity, but without a full spectrum of surgical subspecialty capacity. A Level 4 Trauma Center is generally a small facility which has the capacity to evaluate, stabilize, and transfer major trauma patients to other facilities for more definite care. All of the state's Trauma Centers function within a complex system that includes pre-hospital care and transport, definitive surgical or critical care, rehabilitation, and injury prevention. In addition, all levels of Trauma Centers participate in the state's trauma data registry.

The trauma facilities are primarily clustered around metro Atlanta, Augusta, Columbus, Macon, and Savannah, leaving huge gaps in the state for persons requiring timely, quality trauma care. Another issue affecting trauma care is the lack of direct dial 911 in 21 counties in south and middle Georgia, areas traversed by I-75, I-20, I-16, and I-95. The lack of facilities and the ability to rapidly get trauma patients to quality definitive care during the initial "golden hour" negatively impacts patient survival and outcomes.

Critical Care Access Hospitals: Sixty-seven rural hospitals are eligible for Critical Care Access designation; 34 hospitals are currently designated. This federal program raises Medicare reimbursement rates for eligible facilities and provides cost-based reimbursement from Medicaid and the Georgia State Health Benefit Plan for outpatient services in return for agreeing not to: 1) operate any more than 25 beds, 2) team with a larger facility to deliver inpatient care, and 3) limit inpatient care provided to an average of no more than 96 hours.

Tertiary Hospitals: Six designated regional tertiary hospitals provide a system of high-risk maternal and infant care services including transportation, prenatal care, delivery, post-partum care, and newborn care. These tertiary hospitals, located in Atlanta, Macon, Augusta, Columbus, Albany, and Savannah, also provide outreach and education to area providers to ensure a seamless community-based system. All women and infants who are high-risk are accepted for services at the six regional tertiary hospitals without regard to income. Women and infants who meet program medical criteria (high-risk) and whose incomes are below 250% of the FPL are eligible to receive services.

Impact of the economic downturn on Georgia's hospitals: In 2009 the Georgia Hospital Association surveyed its membership to help determine the impact of the state's economic downturn on hospitals throughout the state. Sixty-three (63) hospitals and health systems responded to the survey. The data showed, like other Georgia businesses, the state's hospitals have had to make difficult operating decisions while still trying to meet the health care needs of the individuals they serve. Survey respondents indicated that:

- More than six of 10 Georgia hospitals had to, or were considering, reducing staffing
- One of three had to, or were considering, reducing services; Nearly three out of four hospitals had experienced increases in bad debt and charity care since October 2008
- Six of 10 hospitals reported that the recession had affected their ability to meet day-to-day operating expenses
- Nearly three of four hospitals were postponing or reconsidering capital expenditures
- Over half had experienced declines in elective procedures (often the most profitable

procedures for hospitals)

- More than half had seen a decline in charitable contributions/philanthropy
- More than eight of 10 hospitals reported an increase in physicians who were seeking support from the hospital (i.e., hospital employment, increased payment for services)

With the continued economic downturn and the increasing number of individuals who have lost their jobs and health insurance, hospital emergency rooms, which by law must see all patients regardless of ability to pay, provide a safety net for the state's uninsured and underinsured. As a result, Georgia hospitals are experiencing even greater financial pressure.

The state's Medicaid shortfall has added to the financial pressures Georgia hospitals are facing. To fund Medicaid in FY 2011, the 2010 Georgia General Assembly passed a 1.45% bed tax on hospital beds. The full impact of this tax on Georgia's public and private hospitals has not been determined. Major changes are also anticipated with implementation of federal health care reform signed into law in March 2010. The increase in insured individuals as a result of the legislation could help hospitals, particularly safety net hospitals that currently serve many uninsured patients. It could also mean an increase in the number of Medicaid patients that a hospital serves. Hospitals may lose money if their Medicaid patient population increases significantly because Medicaid does not reimburse hospitals the full cost of a Medicaid patient's care.

****Community Health Centers****

Georgia's CHCs offer a comprehensive range of primary health care and other services including around the clock care, acute illness treatment, prenatal care, well-child care, physicals, preventive services, health education, nutritional counseling, laboratory, x-ray and pharmacy services. The state's network of 28 Community Health Centers serves over 238,000 Georgians each year in over 70 of the state's 159 counties.

****Behavioral Health and Developmental Disabilities****

The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) provides treatment and support services to Georgia citizens with mental illnesses and addictive diseases, and support to people with mental retardation and related developmental disabilities. DBHDD has nearly 9,000 employees whose work is structured in three divisions by disability area: Mental Health, Addictive Diseases, and Developmental Disabilities.

DBHDD operates seven regional state hospitals and provides and oversees community-based services across the state. Five regional DBHDD offices negotiate contracts, manage resources assigned to the regions for community-based and state hospital services, and ensure service access, protection of client rights, and prevention of client neglect and abuse. Each region is required to have an array of mental health and substance abuse services available through a variety of contracted providers. Determination of service needed is based on individual assessment.

In July 2006, the State of Georgia implemented the Georgia Crisis and Access Line (GCAL), a single toll-free telephone number (1-800-715-4225) that individuals can call 24 hours/seven days a week to be connected to local services for mental health, developmental disabilities, and addictive diseases. Previously, each region of the state had a different access number. Managed by Behavioral Health Link (BHL), GCAL was one of sixteen finalists for the 2009 Innovations in American Government Awards from the Harvard Kennedy School's ASH Institute for Democratic Governance and Innovations Award. BHL Call Center clinicians provide brief clinical screening, triage, and service linkage for 25,000 incoming calls per month. Last year, BHL answered over 300,000 incoming calls.

Target populations include adults with chronic mental illness, adults with severe addiction problems, parents or caregivers of children or adolescents with severe emotional disturbances,

and adults and adolescents struggling with suicidal thoughts or a psychiatric crisis. Telephone interpreting services are provided to callers with limited English proficiency. The level of service needed is determined and callers are offered a choice of providers. GCAL is staffed with professional social workers and counselors to assist those with urgent and emergency needs. Those callers who need more routine services are directly connected with the agency of their choice and given a scheduled appointment. In addition, a website, www.mygcal.com, offers users a list of DBHDD providers and services by county as well as contact information for the regional office that services the user's community.

Many individuals approach the state DBHDD service delivery system looking for various types of help. (Not everyone who seeks assistance is in need of mental health or addictive disease services.) In order to efficiently and expeditiously address the needs of those seeking assistance, a quick assessment is carried out by GCAL clinicians using DBHDD Core Customer child and adolescent and adult eligibility criteria. If the individual does not have sufficient indications of a mental illness and/or substance related disorder, then an appropriate referral to other services or agencies is provided. If the child, adolescent, or adult does appear to have a mental illness and/or substance related disorder, he/she is referred to the designated agency or agencies within their service area for a comprehensive evaluation, treatment and support services as appropriate. Consumers are able to specify the distance they are willing to travel and the call center identifies service providers within that proximity to the individual's zip code location. Consumers can also choose to contact local providers directly for services.

DBHDD's Developmental Disabilities services are focused on people with developmental disabilities with chronic conditions that were developed before age 22 and that limit their ability to function mentally and/or physically. State-supported services are aimed at helping the family continue to care for a relative when possible, serving people who do not live with their families in a home setting, and promoting independence and self-determination. The services a person receives depend on a professional determination of level of need and the services and other community resources available. Services may include family support, supported employment, respite services, inpatient services in one of seven state-operated hospitals that serve people with severe and profound mental retardation (individuals may be admitted only under special circumstances for temporary and immediate care during a crisis), community residential alternative or community living support, and community access services that help meet an individual's needs and preferences for active community participation.

****Medicaid****

The Department of Community Health (DCH) administers the state's Medicaid and PeachCare for Kids State Child Health Insurance (CHIP) programs. Of DCH's \$12.3 billion FY 2010 budget, Aged, Blind and Disabled Medicaid accounts for 42.9% of the DCH budget, Low-Income Medicaid 38.9%), and PeachCare for Kids 4.2%. Medicaid's FY 2010 state appropriation of \$1,390,745,935 reflected a cut of \$664,946,931 from the FY 2009 base.

Georgia's Medicaid program provides health care for 1.4 million children, pregnant women, and people who are aging, blind and disabled. The average monthly Medicaid enrollment in FY 2008 was 1,253,453. The average annual payment per Medicaid recipient was \$5,005.

To be eligible for Low-Income Medicaid, adults and children must meet the standards of the former Aid to Families with Dependent Children (AFDC) program (family of four income limit of \$6,000 per year). Pregnant women and their infants with family income at or below 200% of the FPL are eligible for Right from the Start Medicaid for Pregnant Women and Their Infants (RSM Adults and Newborns). Children under the age of one whose family income is at or below 185% of the FPL, children ages one to five whose family income is at or below 133% of FPL, and children ages six to nineteen whose family income is at or below 100% of the FPL are eligible for Right from the Start Medicaid Children (RSM Children).

Pregnant women, children, aged, blind, and disabled individuals whose family income exceeds the established income limit may be eligible under the Medically Needy program. This program allows a person to use incurred/unpaid medical bills to "spend down" the difference between their income and the income limit to become eligible.

For the Katie Beckett program, which covers children up to age 18, income is not considered. Eligibility is based on medical need of institutional care. For individuals who do not meet legal immigration criteria, Georgia's Medicaid program provides coverage for emergency medical services as long as the individual meets all other Medicaid eligibility requirements.

The Children's Intervention Service (CIS) program offers coverage for restorative and rehabilitative services in non-institutional settings (i.e., home, therapist's office, child care, or community setting) for Medicaid-eligible members from birth up to age 21 with physical disabilities or with a developmental delay. CIS services must be determined to be medically necessary, and be recommended and documented as appropriate intervention by a physician. Beginning September 1, 2006, a prior authorization was required for units over eight per member per month for therapy in the same specialty. These units include the evaluation visit. A prior authorization is based on medical necessity and can be approved for up to six months.

In June 2009, 997,488 adults and children were enrolled in Low-Income Medicaid. DCH has projected an increase of 7.7% in enrollment between June 2009 and June 2010 (1,074,482 enrollment) and a 2% increase from June 2010 to June 2011 (1,096,502 enrollment).

In Georgia, the State Children's Health Insurance Program (SCHIP) is called PeachCare for Kids. It provides health care for children through the age of 18 years whose families' incomes make them ineligible for Medicaid but who cannot afford their own health insurance. The children must live in a home where the income is at or below 235% of the FPL. Health benefits include primary, preventive, specialist, dental care and vision care. PeachCare for Kids also covers hospitalization, emergency room services, prescription medications and mental health care. Each child in the program has a Georgia Healthy Families Care Management Organization (CMO) who is responsible for coordinating the child's care.

PeachCare for Kids exceeded its two year enrollment goal in its first year of operations. Georgia ranks fourth nationally in numbers of enrolled children. Only California, New York, Florida, and Texas have enrolled more children. In June 2009, 205,370 children received services funded by PeachCare for Kids, down from the 250,000 children enrolled in 2008. Enrollment is projected to increase by 8% by June 10, 2010 (221,972 enrollment) and 8% between June 2010 and June 2011 (239,917 enrollment). The average annual payment per child was \$1,399.

In Federal Fiscal Year (FFY) 2010, the state's enhanced SCHIP Federal Medicaid Assistance Percentage (FMAP) is 75.57 percent, with Georgia eligible to receive \$3 in federal funding for every \$1 of state funding. The FY 2010 state appropriation was \$87,937,542, a cut of \$10,735,387 from the FY 2009 base.

Effective June 1, 2006, Georgia implemented Georgia Families, a managed care program through which health care services are delivered to members of the state's Medicaid and PeachCare for Kids programs. Georgia Families is a partnership between DCH and private Care Management Organizations (CMOs) to ensure accessible and quality health care services for Medicaid and PeachCare for Kids managed care members. DCH contracts with three CMOs: AMERIGROUP Community Care, Peach State Health Plan, and WellCare of Georgia, Inc.

By providing a choice of health plans, Georgia Families intends to enable members to select a health care plan that fits their needs. DCH's Medicaid Division monitors the CMOs to ensure compliance with contractual requirement standards for contract management, member services, provider services, and quality services.

Georgia Families provides health care services to children enrolled in PeachCare for Kids and certain men, women, children, pregnant women, and women with breast or cervical cancer covered by Medicaid. Excluded populations include children in foster care and the remainder of Georgia's Medicaid population, including aged, blind, and disabled citizens.

Children with disabilities who have not been determined eligible for Supplemental Security Income (and do not therefore receive the previously mentioned Children's Intervention Services under Medicaid Aged, Blind and Disabled program), receive services from the CMOs through the Low Income Medicaid program.

****Public Health****

Service delivery in the state's public health system is carried out by 159 county boards of health. These boards of health are combined into 18 districts, ranging from one to 16 counties in size. Each district is led by a physician district health officer who reports to the state office of the DCH Division of Public Health. The county boards of health provide direct health care services, environmental health activities, and work with community partners in their county around issues of common concern. Approximately 97% of the county health departments' funding comes from the state in the form of general Grants-in- Aid (GIA). The FY 2010 general GIA state appropriation was \$68,154,008; a decrease of \$3,703,320 from the FY 2009 base.

In addition to budget cuts, Georgia's public health services have been impacted by a public health nursing shortage. Contributing factors include budget constraints, non-competitive salaries, extended job vacancies, ineffective recruitment and retention, staffing reductions, job furloughs, and bureaucratic hiring practices. Georgia's overall registered nurse shortage, aging population of nurses, and inadequate number of baccalaureate nursing graduates are also factors.

B. Agency Capacity

The Maternal and Child Health Program (MCHP), part of the Division of Public Health (DPH), Department of Community Health (DCH), is Georgia's Title V agency. The charge of the MCH Program is to improve the health of mothers, children, and their families through education, provision of direct services (family planning, children with special health care needs, early intervention, and Special Supplemental Nutrition Program for Women, Infants, and Children -- known as WIC), population-based interventions (newborn screening and oral health preventive services), and the support of the public health infrastructure through the administration of Title V Block Grant funds.

Core MCH services include:

- Universal Newborn Hearing Screening Initiative (UNHSI)
- Newborn Metabolic and Hemoglobinopathy Screening
- Early intervention
- Coordinated care for children with special health care needs (CSHCN)
- Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
- Family planning
- Regional Perinatal Centers
- Coordinated care and outreach for children
- Prenatal care
- Health education including breastfeeding support, nutrition, and Sudden Infant Death Syndrome (SIDS)
- Oral health preventive services
- Children and Youth with Special Needs, Children's Medical Services

Funding sources include: WIC = \$320 million (federal)

- Title X (family planning) = \$8 million (federal) and a 10% state match
- Early intervention = \$14.7 million (federal), \$15.9 million (American Recovery and Reinvestment Act), and \$9.7 million (state)
- Universal Newborn Hearing Screening Initiative = \$1.3 million (state) and \$0.2 million (federal)
- Newborn Metabolic and Hemoglobinopathy Screening = \$3.5 million (state) and \$0.6 million (federal)
- Regional Perinatal Centers = \$15 million (federal), 35%/65% state/Medicaid match
- Oral health preventive services = \$2.3 million (state) and \$0.6 million (federal)
- Title V Maternal and Child Health Block Grant = \$16 million (federal) and \$12 million (state)

STATE STATUTES RELEVANT TO TITLE V PROGRAM: The mission of Public Health in Georgia is to promote and protect the health of Georgians. The Official Code of Georgia (31-2-1 and 31-3-5) supports this mission by empowering DCH and the local county boards of health to employ all legal means to promote the health of the people. County Boards of Health develop and establish community-based systems for preventive and primary care services for pregnant women, mothers and infants, children and adolescents through local planning, direct provision of services and collaboration. Relevant DCH O.C.G.A. Titles include 4, 8, 10-1-393, 12, 15-11, 15-21, 16, 17-18-1, 19, 20, 34, 36, 40, 42, 43, 45, 46, 49, and 50. Other relevant state statutes include: Newborn Metabolic -- O.C.G.A. 31-12-6 and 31-12-7; Well Child -- O.C.G.A. 31-12-6 and 31-12-7; UNHS -- O.C.G.A. 31-1-1-3.2; School Health -- O.C.G.A. 20-2-771.2; Children 1st -- O.C.G.A. 31-12-6, 31-12-7, 31-1.3.2; Newborn Hearing Screening -- O.C.G.A. 31-1-3; Family Planning -- O.C.G.A. 49-7-03; and Perinatal Case Management -- 31-2-2.

Two governing bodies, the Board of Community Health and the 159 county boards of health, have key oversight and regulatory responsibilities. The State Board of Community Health's nine members are appointed by the Governor. The Board of Community Health establishes the general policy to be followed by DCH and makes budget recommendations. At the county level, boards of health, each with seven members, are required by state statute. These boards oversee the activities and budgets of the local public health departments and have regulatory and enforcement powers.

Georgia law permits the establishment of administrative multi-county health districts with the consent of county governments and boards of health in the counties involved. Georgia's 18 public health districts range in size from one to 16 counties. Each district has a health director, appointed by the DCH Commissioner and approved by the boards of health of the concerned counties. Typically, each district health office is staffed by a health director (a physician), administrator, program manager, community epidemiologist, chief of nursing, environmentalist, and program and support staff. District health offices are located in the "lead" county of the district, usually the largest county in population. Local level responsibilities are set forth in county Grant-in-Aid (GIA) contracts which describe programmatic activities and provide financial support to carry them out. Direct services are provided by the county health departments. Funds to support county health departments come from fees, state Grant-in-Aid, county taxes and grants.

CAPACITY TO PROVIDE TITLE V SERVICES: The MCHP's capacity to provide: 1) preventive and primary care services for pregnant women, mothers, and infants; 2) preventive and primary care services for children and adolescents; and 3) services for children with special health care needs; 4) rehabilitation services for blind and disabled children under the age of 16 receiving benefits under Title XVI; and 5) family-centered, community-based, coordinated care including care coordination services for children with special health care needs and facilitate development of community-based systems of services for such children and their families is described below.

The Maternal and Child Health Program, led by Brian C. Castrucci, M.A., is organized into five areas: Child Health; Community Health Services; MCH Epidemiology; Nutrition and WIC; and Capacity Building.

The Child Health Section includes:

- Children and Youth with Special Needs

- * Babies Can't Wait
- * Children's Medical Services

- Comprehensive Child Health

- * Children 1st
- * First Care
- * Health Check
- * Early Childhood Comprehensive Systems (ECCS Initiative)
- * SIDS/Other Infant Death

- Newborn Screening Unit

- * Newborn Metabolic and Genetic Screening
- * Universal Newborn Hearing Screening and Intervention

Babies Can't Wait (BCW) is Georgia's statewide interagency service delivery system for infants and toddlers with developmental delays or disabilities and their families. The Georgia Division of Public Health is the lead agency responsible for administering the BCW program in Georgia. Through the MCHP, DPH ensures that services are provided in accordance with federal guidelines; that families have access to the services which are needed to enhance their child's development; and training is available to ensure that professionals who work with children and families have up-to-date information. Core services provided at no cost to families include developmental evaluation/assessment, individualized family service plans (IFSP), procedural safeguards (parent's rights), service coordination, and transition planning. Services subject to a system of payment (i.e., private insurance, Medicaid, family cost participation) include assistive technology, health services, nutrition services, physical therapy, special instruction, audiology, medical diagnostic services, psychology services, speech/language therapy, family training and counseling, nursing services, physical therapy, occupational therapy, social work, and vision services. BCW is administered through the 17 public health district offices throughout the state, and Easter Seals of North Georgia in the Gwinnett District. Parent to Parent of Georgia manages a statewide directory of information about local BCW programs that can be accessed by calling 1-800-229-2038.

Children's Medical Services (CMS) serves children and youth with disabilities age birth to 21 that have a medical diagnosis on the approved CMS list and meet financial eligibility criteria. CMS provides care coordination, specialty medical evaluations and treatment for eligible children and youth who have complex medical conditions. Core CMS services include care coordination with a comprehensive plan of care, assurance that a child has a medical home with a primary care provider, and transition planning for youth ages 16 to 21 years of age. Services for eligible conditions include comprehensive medical evaluations, specialty medical/surgical care, diagnostic tests, durable medical equipment, inpatient/outpatient hospitalization, and medications.

Children 1st is the "single point of entry" to a statewide collaborative system of public health and other prevention based programs and services. This system allows children at risk for poor health and developmental outcomes to be identified early and gives them a chance to grow up healthy and ready for school. Participation is voluntary and there are no financial requirements for enrollment into the program. Core services include identifying high-risk births in Georgia; screening all births and children up to age five; assessing children and families at risk; referral/linkage of children and families with risk conditions to appropriate services; and monitoring of individual children from birth to age five with risk conditions. The Electronic Birth

Certificate assists Children 1st in identifying newborns with or at risk for poor health and development. In addition, many health and community providers refer families to Children 1st. Children 1st refers families to other public health programs as appropriate, including BCW and CMS. Linkages are made to Medicaid and PeachCare for Kids as appropriate. Families may also access services from agencies such as Healthy Families Georgia, Family Connection Partnership, and Head Start. Children 1st is present in all 18 public health districts with services implemented in all Georgia counties to provide a system of support for families.

First Care provides services to infants, birth to age one, who are at increased risk for health and developmental problems due to medical conditions at birth. Services may include voluntary in-home or clinic-based nursing assessment, nursing intervention, and care coordination. Services are designed to provide families education, support, and linkage with a medical home and community resources and programs to improve health and developmental outcomes and enhance parenting skills.

Health Check is Georgia's well child or preventive health care program for Medicaid-eligible children birth to 21 years of age and PeachCare for Kids-eligible children birth to 19 years of age. Health Check screenings provide children and adolescents access to comprehensive medical care to support early detection and treatment of health conditions and aid in prevention of advanced illness and disability. Health Check screenings are provided by eligible providers according to a schedule based on recommendations of the American Academy of Pediatrics and include the following services: comprehensive health and developmental history, comprehensive physical exam, vision and hearing screening, appropriate immunizations, health education/anticipatory guidance, laboratory tests, and dental referrals.

The Early Childhood Comprehensive Systems (ECCS) Initiative is focused on developing a framework that fosters integrated early childhood systems at the state and community levels to support children, ages birth to five, who are healthy and ready to learn. The federally funded ECCS Grant is working to build a comprehensive early childhood system through the collaboration of Georgia service providers, families, communities, and policymakers. ECCS addresses five core elements: access to medical and dental care, social-emotional development and mental health, early care and education, parenting education, and family support. The Initiative has two goals: 1) State partnerships around ECCS principles and elements are strengthened through collaborative projects, including assessing, prioritizing, and addressing early childhood statewide resources, gaps and barriers; and 2) All children birth to five receive coordinated, ongoing standardized developmental screening at recommended levels as well as when observation yields concerns about delayed or disordered development. ECCS work is guided by the ECCS Collaborative Partners Steering Committee, which includes representatives from numerous partnering agencies, all of whom work with or have an interest in children ages birth to five.

Sudden Infant Death (SIDS)/Other Infant Death provides new parents and infant caretakers with information about sleep safety and how to reduce the risk of SIDS, and links families who experience the death of a baby with community resources to assist them with their grief. The Georgia Crib Matching Program began in late 2007. Participating agencies must complete SIDS Risk Reduction Training and agree to purchase a minimum of five new/unused portable cribs with a bassinet. MCH will match three cribs to the respective agency. Families receiving a crib must meet specific eligibility requirements

The goal of Newborn Metabolic and Genetic Screening is to assure that every newborn in Georgia has a specimen collected for newborn screening tests prior to discharge from the hospitals; all infants with results outside the normal limits receive prompt and appropriate follow-up testing; and those diagnosed with a disorder are entered into and maintained on appropriate medical therapy. Core services include population screening for all newborns (approximately 150,000 live births/year); follow up of unsatisfactory or abnormal screening results; and diagnosis and referral to intervention.

Universal Newborn Hearing Screening and Intervention's goal is to screen every newborn (approximately 150,000 live births/year) for hearing loss prior to hospital discharge, and ensure infants not passing the initial and a repeat screening receive appropriate diagnostic evaluation before three months of age and when appropriate, are referred to intervention by six months of age.

The Community Health Services Section includes:

- Oral Health Unit
- Perinatal and Women's Health Unit
- * Family Planning
- * Regional Perinatal Centers

The mission of the Oral Health Unit is to prevent oral disease among Georgia's children through education, promotion of healthy behaviors, preventive interventions (such as sealants), and early treatment. Eligible populations include children with Medicaid/PeachCare for Kids; low income, uninsured children in need of oral health care; special needs children; pregnant women on Medicaid; and in some district practices, adults on a sliding fee scale. School sealant programs are directed at schools with more than 50% of the children on free or reduced lunch. Core services include school-based oral disease prevention and treatment programs for low income children; clinic-based dental treatment and prevention services for low income children and adults; and monitoring, supervision, and surveillance of public community water fluoridation programs. Approximately 96% of Georgians using community water services receive optimally fluoridated water.

Family Planning provides comprehensive reproductive health services to women of childbearing age and their partners. Services include physical exams; birth control counseling and supplies; abstinence skills training; immunizations; and screening for cancer, high blood pressure, diabetes, HIV and other sexually transmitted infections. The Georgia Family Planning Program also provides screening, counseling and referral for risk factors affecting women's health such as substance abuse, poor nutrition, cigarette smoking and exposure to violence. Services are provided in accordance with the federal guidelines.

In April 2009, DCH, in collaboration with community and agency partners, embarked on an initiative, known as Planning for Healthy Babies (P4HB), to reduce Georgia's low birth weight rate from 9.5% to 8.6% over a five year time span. Currently, the Georgia Medicaid Program provides prenatal coverage for pregnant women with monthly incomes at or below 200% of federal poverty level (FPL). These women are eligible for family planning services through the end of the month in which the 60th postpartum day falls. After 60 days, women whose income exceeds the categorical limits for participation in the traditional Medicaid program lose eligibility for all benefits, including family planning. Implementation of the P4HB program will extend eligibility for family planning services to women ages 18 to 44 years who are at or below 200% of the most current FPL; and provide inter-pregnancy care to women at or below 200% of FLP who have previously delivered a very low birth weight baby. The waiver will begin in January 2011 and end December 31, 2015.

The Designated Regional Perinatal Centers provide multidisciplinary care to high risk mothers and infants through six designated regional perinatal centers. Core services include high-risk perinatal services including transportation, prenatal care, delivery, post-partum care, newborn care, high-risk developmental follow-up and referrals to community and public health providers including, family planning, WIC, Children's 1st, and BCW. Additional services include physician outreach and education to area providers to ensure a seamless community-based system.

Perinatal/Women's Health is an outreach partner/sponsor of text4baby, a new free mobile information service providing timely health information to pregnant women and new moms from pregnancy through a baby's first year. These messages focus on a variety of topics critical to maternal and child health, including birth defects prevention, immunization, nutrition, seasonal flu, mental health, oral health, and safe sleep. Text4baby messages also connect women to prenatal and infant care services and other resources.

The MCH Epidemiology Section works to increase the access, use, and quality of MCH program relevant data; ensuring that MCH programs and program partners have access to the science necessary to effectively guide program and policy development.

The goal of Georgia's Nutrition and WIC Section is to provide quality supplemental nutritious foods through a complex network of over 1,600 authorized retailers; nutrition and breastfeeding education, counseling, and support; and applicable referral-related services to assure that its targeted populations are eating healthy; practicing breastfeeding for recommended durations; being adequately physically active; and accessing complementary health services. In addition to providing technical assistance to Georgia's WIC, the Nutrition Services Unit conducts population-based services within the three core Public Health functions (assessment, policy development, and assurance); increases the demand and provides options for achieving healthy eating lifestyles; enables Georgia citizens to make informed food choices; and creates public/private partnerships to promote nutrition-related policies, practices, and system development statewide. Georgia's WIC, the nation's fifth largest, provides various types of services to over 310,000 participants through Georgia's 18 public health districts, two contract agencies, and its authorized retailers.

The Capacity Building Section supports the application of best practices and standards of care in order to enhance programs at the state and local levels by providing continuous quality improvement (CQI) and technical assistance (TA). The office is charged with leveraging resources, eliminating duplication of effort, ensuring accountability, and assuring a competent work force. The CQI Unit is responsible for developing, implementing, and supporting a standardized system of monitoring and compliance for MCH programs and initiatives. The TA Unit is responsible for ensuring that MCH services are delivered to children and families by competent staff and providers through technical assistance and training.

BUILDING MCH CULTURAL AND LINGUISTIC COMPETENCY: Many of the state's health districts have identified growing immigrant populations and increases in clients with limited English proficiency as emerging trends that are having an impact on service delivery in the districts. Latinos, primarily Mexicans, are the most rapidly growing minority group in Georgia. DPH is committed to ensuring that limited English proficient (LEP) and sensory impaired (SI) clients have meaningful access to all programs and activities conducted or supported by the department. DPH's strategy for providing meaningful access for LEP and SI customers involves assessing language access needs statewide; recruiting and training "qualified" interpreters and bilingual staff; developing a centralized databank of language resources; translating vital forms and informational documents; forming partnerships with community groups for outreach and education; providing diversity training to DPH employees; and implementing a procedure for monitoring services and resolution of complaints. DPH is also working to reduce and eliminate access barriers that discourage the enrollment of all eligible program participants, including those in immigrant and mixed-status families. State and local public health staff, including MCH staff, are also able to draw on several key cultural competency resources, including the DPH's State Refugee Resettlement and Health Programs and Office of Communications, and DCH's Office of Health Improvement, Minority Health. The Office of Communications has widely disseminated a "Directory of Qualified Interpreters and Translators and Multi-Ethnic Community Resource Guide. Minority Health's Information Center has resource materials that focus on health issues relating to minority populations.

Racial and ethnic minorities make up over one-third of Georgia's population, but their disease burden is significantly higher. The DCH Office of Health Improvement, Minority Health works to eliminate the discrepancy in health status between minority and non-minority populations in Georgia. Major focus areas include:

- Identifying, assessing, and analyzing issues related to the health of minority populations;
- Working with public and private organizations to address specific minority community health needs;
- Monitoring state programs, policies, and procedures to assure that they are inclusive and responsive to minority community health needs; and
- Facilitating the development and implementation of research enterprises and scientific investigations to produce minority-specific findings.

Minority Health's work is supported by the Georgia Minority Health Advisory Council. Twelve members, including representatives from the Centers for Disease Control and Prevention, Georgia Rural Health Association, National Center for Primary Care, Center for Pan Asian Services, Medical Interpreter network of Georgia (MING), Children's HealthCare of Atlanta, Georgia Academy of Family Physicians, Georgia Dental Society, DCH, and medical providers, address health disparities and other health care concerns of Georgia's African American, Hispanic/Latino, Asian/Pacific Islander, and American Indian/Alaska Native populations. The Council has provided leadership in the development of a health care strategic plan to address improvement in the health status of minority populations in Georgia and in the work of the Georgia Health Equity Initiative. The "Georgia Health Equity Initiative -- Health Disparities Report 2008: A County-Level Look at Health Outcomes for Minorities in Georgia" provides data and information to help providers and the public understand health disparities, identify gaps in health status, and target interventions in areas of greatest need. The report is the first of its kind to focus solely on minority health outcomes for each of Georgia's 159 counties.

At the local level, public health districts efforts to meet the needs of non-English speaking clients have included hiring bilingual staff and/or utilizing translators or interpreters, conducting staff cultural diversity training, using language assistance phone lines, special health fairs in collaboration with local churches and other community organizations, and offering forms and patient education materials in Spanish and other languages. Districts have also engaged in social marketing and outreach to inform non English speaking clients of available public health services.

To provide meaningful access to services for LEP and sensory impaired (SI) customers, DPH service sites are required to have: 1) Notice of Free Interpretation Service Wall Posters prominently displayed in all reception and intake areas; 2) Notice/Policy of Nondiscrimination prominently displayed in all reception and intake areas; 3) the "I Speak" DPH card, which accommodates the identification of 38 languages likely to be encountered, accessible for DPH staff use; 4) State LEP/SI Plan and accompanying LEP/SI Policy and Procedures accessible for reference for all staff; 5) LEP/SI Intake and Tracking Form, with instructions, accessible for staff use; 6) "Waiver of Right to No-Cost Interpreter Services" form and Discrimination Complaint Form accessible for DPH staff use; 7) a sign posted identifying the Language Access Coordinator and Language Access Team Member for the Division or Office; 8) current listing of DPH Language Contractors, other contractors providing services, and contact information for a telephone interpretation service; 9) list of translated materials by title, date, form number, and language; 10) method of tracking the number of LEP/SI customers receiving services; 11) LEP/SI central file or appropriate alternative for paperless offices; 12) completed Local Language Access Plan; and 13) LEP/SI Reference Notebook (including items listed above) for use by staff, generally housed at the front desk.

All health districts are provided funding through Grant-in-Aid to cover the cost of language interpreters for families receiving hearing follow-up services.

BUILDING MCH COMPETENCIES: DPH offers state and local staff coordinated training and development activities to improve knowledge and job performance. DPH use of the video interactive conferencing systems (VICS) is increasing local public health staff participation in coordinator meetings and trainings. A range of VICS training is provided including New Employee Orientation (Parts I and II), Civil Rights Training, Policy and Procedures revisions, ARRA Stimulus and Stimulus Money Requirements, Data Overview, Family Planning, WIC Food Package Policy, WICS PARS Time Reporting, CMS training, and Infection Control Updates. Quarterly district Women's Health, CMS, and WIC coordinators meetings are held either via VICS or face-to-face to share information and identify opportunities to collaborate.

All new DPH state and district staff receive employee orientation training. In addition, new state MCH staff receive information on the Health Resources and Services Administration's Maternal and Child Health Bureau and the Maternal and Child Health Block Grant.

BUILDING PUBLIC AWARENESS FOR MCH: The Office of Communications serves as DCH's primary point of contact for all marketing, branding, media relations, and internal and external communications activities. The Communications team focuses its efforts on creating and maintaining a consistent brand and messaging for DCH. Specifically the team creates fact sheets for all of DCH's offices, divisions and programs, writes and distributes press releases and media advisories, designs and implements member and provider educational and promotional campaigns, and works with subject matter experts to create legislative briefs. The Office of Communications is also responsible for Intranet and Internet Web site maintenance, and oversees the Governor's Office of Customer Service program at DCH. The DCH website (<http://dch.georgia.gov>) includes division and program descriptions, a link to DCH publications, public notices, public meeting schedules, grant announcements, press releases, and general assembly presentations. The DPH web site (<http://health.state.ga.us/>) provides overviews of all public health programs and services, including MCH. Each program description includes state office contact information.

C. Organizational Structure

The Department of Community Health (DCH) framework in which MCH functions is depicted in the attached organizational charts. The Georgia General Assembly created DCH in 1999 by combining the four state agencies that were responsible for purchasing and regulating healthcare into a single, new agency. The DCH is now the main state agency in Georgia that provides health care planning and purchasing. In 2009, the DCH took over the duties of the Division of Public Health and Emergency Preparedness, formerly located in the Department of Human Resources, in addition to its normal functions. The DCH is also the sole state agency for Medicaid.

The DCH Commissioner is appointed by the governor of Georgia and is accountable to the State Board of Community Health. The Board provides general oversight of DCH's activities by establishing policy, approving goals and objectives and other appropriate activities. The Commissioner is in charge of overseeing the ten divisions and six offices that make up the DCH. Clyde L. Reese, III, Esq. serves as the DCH Commissioner. Mr. Reese has previous experience as an Assistant Attorney General for the State of Georgia, General Counsel for the State Health Planning Agency, and Deputy General Counsel and General Counsel of DCH.

The DCH Management Team includes the Chief Operating Officer; Chief Financial Officer; Director of Communications; Director of Healthcare Facility Regulation; Director of Legislative and External Affairs; Chief of the Medicaid Division; Inspector General and Chief of the Program Integrity Unit, Internal Affairs, and Audit Unit; Director of the Division of Public Health; Director of the State Health Benefit Plan; and Chief of Emergency Preparedness and Response Division.

DCH Divisions:

-The Emergency Preparedness and Response Division manages the Centers for Disease Control and Prevention's Public Health Emergency Preparedness Cooperative Agreement and the Health and Human Services Assistant Secretary for Preparedness and Response Hospital Preparedness Program Cooperative Agreement. Its activities include planning support for pandemic influenza and the distribution of medication during disease outbreaks. Injury Prevention, located in the Division along with the EMS and Trauma Programs, provides technical assistance in program evaluation and coalition building to local community groups; provides injury data to community groups and the public at large; distributes safety equipment such as child safety seats, bike helmets, smoke detectors, and dissemination of knowledge on proper use of safety equipment; and provides general support to local coalitions in helping promote safe and injury free life styles and behaviors.

-The Division of Financial Management deals with the DCH's financial needs, including its accounting and budgeting.

-The Office of General Counsel takes care of several administrative and legal tasks for the DCH. It creates policies to comply with federal and state record requirements, drafts rules and regulations to be considered by the Board of Community health, and supplies services for the legal part of the State Health Benefit Plans.

-Healthcare Facility Regulation Division ensures that healthcare providers are safe and competent and comply with professional standards.

-Information Technology is in charge of maintaining the systems for processing and collecting Medicaid and PeachCare for Kids payments.

-The Office of Inspector General prevents and investigates fraud related to Medicaid, PeachCare for Kids, and the State Health Benefit Plan.

-The Division of Public Health promotes healthy lifestyles for all Georgians and works to reduce preventable deaths.

-The State Health Benefit Plan gives health insurance to state employees and their dependents.

-The Division of Medical Assistance Plans runs the state Medicaid program, which offers medical help to children, pregnant women, and people with disabilities.

-The Operations Division is in charge of human resources for the DCH as well as several other initiatives including the Office of Minority Health, Office of Women's Health, Georgia Commission on Men's health, Georgia Volunteers in Health Care program, and State Office of Rural Health.

DCH Offices:

-The Office of Communications serves as the DCH's liaison with the media and the public and maintains the DCH website.

-The Office of Health Improvement is a part of the Operations Division and is comprised of the Office of Minority Health, the Office of Women's Health and the Georgia Commission on Men's Health.

-The Office of Health Information Technology and Transparency (HITT) facilitates the exchange of information regarding healthcare between healthcare providers, professionals, and consumers.

-The Office of Legislative Affairs and External Affairs works with the Georgia General Assembly to evaluate and provide input on legislation that relates to public health in the state of Georgia.

-The Office of Procurement Services (OPS) is responsible for procuring the highest quality services possible at the lowest cost possible to fulfill the DCH's need. This office works closely with the Department of Administrative Services.

-The State Office of Rural Health is in charge of providing increased access to healthcare throughout rural Georgia.

Division of Public Health:

At the state level, DPH is divided into numerous branches, sections, programs and offices, and at the local level, DPH functions via 18 health districts and 159 county health departments. The county public health departments offer direct healthcare to low-income people and people in underserved areas of the state, and work with private medical providers to assure these groups receive needed care.

M. Rony Francois, M.D. M.A., M.S.P.H. is Director of the Division of Public Health (DPH). Prior to becoming Director in January 2010, Dr. Francois served as Assistant Secretary of Louisiana's Department of Health and Hospitals Office of Public Health, where he was responsible for the direction and management of the state's public health programs. He has also served as the Secretary of the Florida Department of Health.

Miriam T. Bell, M.P.H., Deputy Director, Public Health Programs and Services, provides administrative supervision of Public Health's programs and services. In addition, she supports the Public Health Director and works closely with the Deputy Director of Administration to manage the day-to-day operations of public health, develops and meets strategic goals and priorities for the Division, and ensures the provision of quality programs and services. Prior to her appointment as Deputy Director, Ms. Bell served for 20 years at H. Lee Moffitt Cancer Center & Research Institute in Tampa, Florida. In her last position she served as their Director of Patient Advocacy and Rehabilitation.

The Advisory Council for Public Health is responsible for providing assistance and guidance to DPH and DCH on all matters regarding public health programs. Eight council members, appointed by the governor, serve one to two year terms.

DPH programs include Health Promotion and Disease Prevention, Maternal and Child Health (see Section B -- Agency Capacity), Infectious Disease and Immunizations, Environmental Health, Epidemiology, the State Laboratory Programs, and Vital Records. Each DPH program and service has responsibilities that inter-relate with MCH activities, requiring strong working relationships.

Health Promotion and Disease Prevention (HPDP) programs implement population-based programs and services aimed at reducing disease risks, promoting healthy youth development, targeting unhealthy behaviors, providing access to early detection and treatment services, and improving management of chronic diseases. Targeted risk behaviors include smoking, physical inactivity, unhealthy eating, lack of preventive healthcare, sexual violence, and reducing risky behaviors in youth. HPDP's Office of Cancer Screening and Treatment includes the Georgia Breast and Cervical Cancer Program, Cancer State AID Program, and breast and cervical cancer treatment for eligible women through the Women's Health Medicaid Program. Office of Chronic Disease Prevention and Wellness programs and services include comprehensive tobacco use prevention activities including tobacco cessation services through the Georgia Tobacco Quit Line; population-based strategies to address chronic disease prevention and management; primary sexual violence prevention; health communication and education; primary prevention strategies to address obesity in children, youth, and adults; adolescent health and youth development; and community capacity building through the provision of technical assistance to community-based organizations to address chronic disease prevention, risk reduction, and positive youth development.

Infectious Disease and Immunization includes the HIV, STD, Tuberculosis (TB), and Immunization Programs. HIV coordinates services through Georgia's HIV Care Ryan White Part B Program and the HIV Prevention Program. The STD Program works to reduce morbidity associated with sexually transmitted disease in Georgia by preventing STDs and their complications in both the public and private sectors through coordinated, comprehensive statewide STD prevention; statewide STD screening; and surveillance of STDs. The TB Program, which has legal responsibility for all TB clients in Georgia regardless of who provides the direct services, identifies and treats persons who have active TB disease; finds, screens, and treats contacts; and screens high-risk populations.

The work of the Immunization Program is carried out through the efforts of trained state staff and through partnership and collaboration with medical organizations, other state agencies, and community coalitions. Vaccine financing is accomplished through the use of state and federal funds to provide vaccines for uninsured and under-insured children in Georgia, and for certain adult populations. The Immunization Program oversees the acquisition, distribution, and management of vaccines through the Vaccines for Children (VFC) Program, as well as vaccines acquired through state and other federal funding.

All health care providers are mandated by law to report to the Georgia Registry of Immunization Transactions and Services (GRITS) all immunizations given to persons of any age. They also can access this database to get updated information on their clients' immunization status. In addition to housing immunization records, GRITS allows providers to track their vaccine inventory, print the Georgia Certificate of Immunization and send reminder/recall notices to clients.

Environmental Health provides primary prevention through a combination of surveillance, education, enforcement, and assessment programs designed to identify, prevent and abate environmental conditions that adversely impact human health. Programs include Chemical Hazards, Food Service, Land Use (On-Site Sewage), Swimming Pools, Tourist Accommodations, Well Water, and Other Programs (i.e., Mosquito-borne Viral Diseases, Indoor Air Quality Assistance).

Epidemiology includes Acute Disease Epidemiology; Chronic Disease, Injury and Environmental; the Office of Health Indicators for Planning (OHIP), and the Georgia Epidemiology Report (GER). OHIP leads DPH's health assessment component, providing evidence about the health status of Georgia's population. OHIP's internal operations include information quality; health statistics; epidemiological modeling and information mining; Geographic Information Systems and spatial analysis; and web-based distribution of health statistics and forecasting models. OHIP's Online Analytical Statistical Information System (OASIS), a suite of interactive tools, provides access to DPH's standardized health data repository. The repository is currently populated with Vital Statistics (births, deaths, infant deaths, fetal deaths, induced terminations), Georgia Comprehensive Cancer Registry, Hospital Inpatient and Emergency Room Discharge, Arboviral Surveillance, Risk Behavior Surveys, and Population data.

The Georgia Public Health Laboratory Program (GPHL) provides screening, diagnostic and reference laboratory services to Georgia citizens through county health departments, public health clinics, physicians, other clinical laboratories, hospitals and state agencies. GPHL's five broad areas of testing and support include: chemistry (Newborn Screening Unit, Lead Screening and Fluoride Testing), Emergency Preparedness (Biological/Chemical Terrorism and Molecular Biology Units), Facilities Support, Microbiology (Bacteriology, Microbial Immunology, Mycobacteriology/ Mycology, Parasitology, and Virology Units), and Operations.

The State Vital Records Office maintains Georgia vital records and events, which are defined as birth, death, fetal deaths (stillbirth), induced termination of pregnancy, marriage and divorce certificates and reports.

An attachment is included in this section.

D. Other MCH Capacity

Title V funds 155 MCH state and district positions. (See attached table.)

SENIOR MCH STAFF QUALIFICATIONS AND CAPABILITIES:

Brian C. Castrucci, M.A., Director of the Maternal and Child Health Program in the Division of Public Health and Title V Maternal and Child Health Block Grant Director, provides leadership for the statewide maternal and child health program. Provide oversight for 140 FTEs and a budget of approximately \$500M. He provides oversight for programs including Georgia's Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), family planning (Title X), Babies Can't Wait (Part C Early Intervention program), Early Childhood Comprehensive Systems grant, the Children First program (Georgia's single point of entry for health-related early childhood services), Title V Maternal and Child Health Block Grant, newborn screening, services for children with special health care needs, oral health, and the Office of Performance Management and Support Services. Prior to serving as MCH Program Director, Mr. Castrucci was the Manager of the Family Health Research and Program Development Unit in the Office of Title V and Family Health at the Texas Department of State Health Services. He has worked with Healthy Start projects in Philadelphia and Texas; has developed case management and other health promotion programs; has implemented surveillance systems to monitor local child death review findings, infant sleep practices, and breastfeeding; and has provided support to the Texas Family Planning Program, the Texas Children with Special Health Care Needs Program, and the Texas Women, Infants, and Children Program. He has published research on topics that include adolescent tobacco use, breastfeeding, HIV/AIDS policy, and pregnancy. Mr. Castrucci also worked at the Philadelphia Department of Public Health, The Robert Wood Johnson Foundation, and the Centers for Disease Control and Prevention. (See attached resume.)

Debbie Cheatham, R.N., D.N.P., Director for the Children and Youth with Special Needs Unit and Title V CSHCN Director, is a doctorally prepared Registered Nurse with over 26 years of experience. She has over 15 years of experience in public health at the state level. Prior to joining the Georgia MCH Program in 2009, she was the Program Administrator for Early Childhood Programs at the Ohio Department of Health where she worked closely with the CSHCN program and instituted a public health nurse consultation visit for all children with a medical diagnosis served in the early intervention program.

Beverly Stanley, B.A., MCH Deputy Director, provides administrative leadership and guidance for all programs in MCH. She earned her B.A. in Human Resource Management at the University of South Carolina. She has over 20 years of experience working in the governmental and private sectors providing management of day to day operations, including financial, human resources, contract, and facility services, maximizing resources for effective and prompt delivery of services to local programs. Most recently, Ms. Stanley served as the Operations Director, providing a comprehensive system for all operational needs, including the Standard Operating Procedures (SOP) in the MCH Program, the development of the only Supervisor's Guide for Orienting New Employees, and a systematic contract management process.

Abdul K. Lindsay, M.Sc.F.T., R.D., L.D., C.P.T., is Director of the Georgia Women, Infants, and Children (WIC) Program. Mr. Lindsay earned his Master of Science and Bachelor of Science degrees in Food Technology and Dietetics, Nutrition and Fitness from the University of Georgia and Florida State University, respectively. He is registered nationally and licensed as a Dietitian and within the State of Georgia. Mr. Lindsay has held leadership positions overseeing and providing various dietetic components including food and nutrition services as well as nutrition education/counseling in Georgia, Florida and North Carolina as a School Nutrition Director, School Nutrition Administrator, Clinical Nutrition Manager, Public Health Community Nutritionist, Public Health WIC Nutritionist and Administrative Dietitian.

Rhonda Simpson, M.S. is the Director of the Capacity Building Section. She has served in various roles for the MCH program for the last nine years. Ms. Simpson has a Master of Science degree in Human Resources from East Central Oklahoma State University and over 16 years of health-related administrative and counseling experience.

Elizabeth C. Lense, D.D.S., M.S.H.A., the Georgia Oral Health Program Director, received her dental degree and completed a residency in Oral Maxillofacial Pathology at Emory University School of Dentistry, and went on to teach Oral Pathology at West Virginia University Schools of Medicine and Dentistry. After returning to Georgia, Dr. Lense taught Oral Histology and Embryology at Georgia Perimeter College School of Dental Hygiene, as well as served as a clinical instructor for oral diagnosis and radiology. While working as a dentist in the dental public health system, she received a Master's degree in Healthcare Administration from Georgia State University, and went on to serve as Director of the Pediatric Dental program for Grady Health System at Hughes Spalding Children's Hospital from 1999-2006. She is an Assistant Clinical Professor in the Department of Pediatrics at Emory School of Medicine, and an adjunct instructor in Pediatrics for Morehouse School of Medicine. She has been on the Board of Directors of the Healthy Mothers, Healthy Babies Coalition since 2000, and served as both Vice-President and President. She is also a member of the Hispanic Health Coalition, Hispanic Dental Association, and the Georgia Dental Society. Dr. Lense completed a Fellowship in Public Health at the CDC Division of Oral Health and now serves as the Georgia's State Oral Health Director.

Sharon C. Quarry, M.S. is the Manager of the Newborn Screening Unit. She received her Master of Science in Medical Genetics/Genetic Counseling in 1997 from Howard University, Washington, D.C. Prior to joining Public Health, she served as the Coordinator of the Newborn Screening Follow-Up Program and piloted a Duchene Muscular Dystrophy Infant Screening Program at Emory University, Department of Human Genetics, Division of Medical Genetics.

Kelli E. Rayford, R.N., M.S.N., P.N.P. is the Program Director for the Comprehensive Child Health Services Unit. She has worked in various areas of Public Health for over 11 years, including positions as a Nurse Practitioner, Nurse Manager, and Nurse Consultant. In her current position, she has oversight of several Public Health programs and services, including Children 1st, Health Check.

Patricka D. Wood, R.N., M.P.H. is the MCH Director of the Perinatal/Women's Health Unit. She received her R.N. training from the University Hospital of the West Indies School of Nursing in Kingston, Jamaica. In 1983, she completed midwifery training at Foresterhill College, Aberdeen Maternity Hospital in Scotland. She received her M.P.H. from Emory University in 1995. She has been employed in high-risk maternal and infant care since 1983.

Medical Oversight: To assure that MCH programs and services reflect sound clinical practice and medical research, the MCH program has contracted with medical consultants to work with MCH programs and services.

Family and community involvement: There are currently nine parent educators who assist the BCW Program with policy development/review, federal grant review, training and support for family members and providers, and encouragement of local and state parent involvement. Eight of the parent educators serve the Dalton, Cobb/Douglas, Clayton, Gwinnett, DeKalb, Valdosta, Albany, and Athens public health districts. In addition, one of the parent educators, who is Hispanic, serves as a statewide multicultural specialist for Georgia's Hispanic families. Recruitment is underway to hire parent educators in the Columbus, Rome, and Waycross districts. Parents of children in BCW and CMS participate in local Interagency Coordinating Council (ICC) meetings in all 18 Georgia public health districts.

The State CMS Office has developed and is facilitating public health district use of a family support group template to foster the establishment of CMS or CYSN family support groups in each district. Currently, all 18 districts have either a Family Action and Support Team (FAST) or a

family support group. Goals of these groups include: providing families with special needs children the opportunity to review and advise on development or revision of current policies and procedures for CMS; providing families with the opportunity to advise CMS of the concerns of children with special health care needs and their families in order to improve and develop programs, using a family-centered approach, that are responsive to the identified needs; providing families an opportunity to come together to network and offer each other support and information; increasing public awareness of programs that are community-based, family-centered, and that provide coordinated, culturally-competent services for children with special health care needs; and establishing a Youth Advisory Council within FAST to guide CMS on the needs and concerns of youth with special health needs and to provide FAST with the youth perspective on the execution of FAST goals.

CMS involves parents in the development of their child's plan of care (POC) and the identification and prioritization of the child's needs as well as the needs of the family. CMS district staff also support clients and their families through various methods, including providing funding for attendance at diabetes and asthma camps; coordinating mothers' nights out; supporting grandparents groups; holding parent workshops; offering sickle cell training for local school nurses; and providing support for asthma coalitions, parent advisory committees, and other community advisory committees, and task forces.

At the district level, CMS staff attend and support local ICC activities. District staff also participate in local Family Connection Partnership initiatives and other community advocacy activities. The Family Connection Partnership Collaborative brings together more than 3,000 local and state-level partners committed to strengthening children and families so they can learn from their peers, share resources, and replicate best practices. The collaborative organizations in the Family Connection Partnership network, which branches out into all 159 counties in Georgia, are committed to improving the quality of life in their communities. Local collaborative organization membership includes concerned citizens, civic groups, local businesses, faith communities, elected officials, and representatives and leaders from state agencies.

Families are surveyed yearly to obtain information about how best the healthcare services their child receives can be improved. Survey findings assist the state office in identifying program strengths as well as areas for improvement.

The Universal Newborn Hearing Screening and Intervention (UNHSI) Stakeholder Committee currently has one parent representative. Sherry Richardson, Director of the Georgia Family Voices Program with Parent of Parent of Georgia, is MCH's Association of Maternal and Child Health Programs (AMCHP) parent representative. She is also one of two regional field coordinators for Family Voices. As Director of the Family Voices Project, she supports families as they negotiate the complex levels of health care systems and policies in the state of Georgia. Parent to Parent of Georgia supports families of children and youth with special health care needs. Parent to Parent currently serves as Georgia's Family to Family Health Information Center. (See Section F -- Other Program Capacity for additional information on Parent to Parent services.)

An attachment is included in this section.

E. State Agency Coordination

Input from Georgia's broad array of public and private sector organizations is key in assisting with the state's MCH policy, planning, and service delivery efforts.

STATE AGENCIES:

Bright from the Start: The Department of Early Care and Learning (DECAL) is responsible for meeting the child care and early education needs of Georgia's children and their families. DECAL oversees a wide range of programs focused on children ages birth to school age and

their families. These programs include: 1) administering Georgia's Pre-K Program; 2) licensing and monitoring the state's center-based and home-based child care facilities (approximately 10,000); 3) overseeing the federal Child and Adult Care Food Program and the Summer Food Service Program; 4) maintaining the Standards of Care Program and Family Homes of Quality to help child care providers enhance their program quality; 5) housing the Head Start State Collaboration Office; 6) administering the federal Even Start dollars to promote family literacy; and 7) providing technical assistance, training, and support to families and child care providers who care for children with special needs. DECAL collaborates with Head Start, Family Connection Partnership, the Department of Human Services Family and Children Services, DPH, and Smart Start Georgia to blend federal, state, and private dollars to enhance early care and education. DECAL and DPH have a memorandum of agreement for enhanced services to support early childhood health and development for children and youth. DECAL is implementing an "Agency Accepted Trainer" pilot program with other state agencies to provide for-credit-training for Georgia child care providers. The MCH Program has been identified as the first "Agency Accepted Trainer." MCH Ages and Stages training opportunities have been posted on the DECAL website and local training will be initiated by summer 2010. In addition, DECAL staff serves on MCH's Early Childhood Comprehensive Systems (ECCS) Steering Committee and on ECCS subcommittees.

The Department of Behavioral Health and Developmental Disabilities (DBHDD) provides treatment and support services to people with mental illness and addictive diseases, and support to people with mental retardation and related developmental disabilities. DBHDD has five regions. Regional offices oversee the network of state-supported DBHDD community and hospital services in the region.

Georgia's services for children and youth who are seriously emotionally disturbed (SED) focus on family support and intervention and preventing crises whenever possible. When crises do occur, public mental health services aim to serve the child in the home or close to home if possible, and to avoid hospitalization, which can be traumatic for young children. The services a child and family receives depends on a professional determination of level of need and the services and other community resources available. Services vary by region and may include: crisis services, outpatient services, community support services, intensive family intervention, and outdoor therapeutic programs. Current child and adolescent mental health initiatives include Community Based Alternatives for Youth (CBAY) and KidsNet Georgia. The CBAY 1915(c) Waiver Home and Community-Based Services demonstration program uses a systems approach that targets youth served by multiple agencies, striving to coordinate, blend, and braid programs and funding to create a comprehensive behavioral system that ensures youth are placed in and remain in intensive residential treatment only when necessary and that a coordinated system of services at the community level is available.

DBHDD's KidsNet Georgia Project is designed to support the transformation of the state's child behavioral health system by strengthening and enhancing the capacity to develop, expand, and sustain behavioral health services across all child-serving agencies for children and adolescents experiencing SED and/or substance abuse and their families. The project is supported by two federal grants (Child and Adolescent State Infrastructure Grant and State Adolescent Coordination Grant). The First Lady's Children's Cabinet serves as the oversight body for the KidsNet Georgia Project. The Cabinet is comprised of state child-serving agency heads at the department and division levels and provides state level support and guidance for grant initiatives that support children, families, and communities. The DCH Commissioner and DPH Director serve on the Cabinet. The MCH Program is represented in the KidsNet Collaborative, the project's operational body which governs the project, and in several of KidsNet workgroups. MCH's ECCS Initiative has been integrated into the project as a subcommittee to help support efforts involving early childhood developmental screening and socio-emotional health. DBHDD staff, including the KidsNet Director, serves on the ECCS Steering Committee. DBHDD also is a member of the Georgia ECCS State Team. As a result of these collaborative activities, the KidsNet Part C Finance Committee has been moved to the ECCS Initiative as an ECCS

Partnership Subcommittee work group.

DPH works with DBHDD around a number of state and local level concerns that relate to the MCH population such as youth risk prevention and tobacco use prevention. A DBHDD Mental Health representative serves on the BCW Interagency Coordinating Council. DBHDD's Division of Addictive Diseases Office of Prevention Services provided Substance Abuse Block Grant funding to help support DPH's 2008-2009 Healthy Families Georgia Mental Health Screening Project which was designed to help decrease the risk of suicide in pregnant and parenting women with depression and address associated issues with mother/child attachment and positive parenting in mothers participating in Healthy Families Georgia programs.

The Department of Education (DOE) oversees public education throughout the state, ensuring that laws and regulations pertaining to education are followed and that state and federal money appropriated for education is properly allocated to the Georgia's 180 local school systems. DOE is comprised of five offices under the State Superintendent of Schools: the Office of Policy and External Affairs; Office of Standards, Instruction, and Assessment; Office of Education Support and Improvement; Office of Finance and Business Operations; and Office of Technology services. The Divisions for Special Education Services and Supports, located in Standards, Instructions, and Assessment, include programs and services that support local school districts in their efforts to provide special education and related services to students with disabilities. These services focus on enhancing student achievement and post-secondary outcomes through implementation of regional and statewide activities for students, families, educators, administrators, and other stakeholders. Targeted areas for services and supports include accessible instructional materials, assistive technology, curriculum access and alignment, dropout prevention, family engagement, least restrictive environment, positive behavior supports, and transition. Additional services include ensuring compliance with federal and state regulations for special education, collecting and analyzing data on education services and outcomes, providing guidance and oversight for federal and state special education funds, and coordinating resolution requirements as required by state and federal requirements. DOE has a memorandum of agreement with the DCH that endorses and encourages joint health and human services and education planning and programming targeting reductions in teen pregnancy, substance abuse, school failure and delinquency. In many parts of the state, strong relationships have been developed between Public Health and the schools.

The Department of Human Services (DHS) provides Georgia with customer-focused human services that promote child and adult protection, child welfare, stronger families and self-sufficiency. DHS includes the Division of Family and Children Services (DFCS), the Division of Aging Services (DAS), the Division of Child Support Services (DCSS), the Office of Residential Child Care (RCC), and support offices. DFCS is responsible for investigating child abuse; finding foster homes for abused and neglected children; helping low income, out-of-work parents get back on their feet; assisting with childcare costs for low income parents who are working or in job training; and providing support services and programs to help troubled families. DFCS and DPH are working to identify and explore opportunities to better serve the children and families of Georgia. Each agency has identified 15 representatives who participated in a meeting on May 27, 2010 to identify collaborative opportunities. Collaboration goals include: 1) determining how DFCS and DPH can more efficiently serve the same customer; 2) identification of early intervention opportunities in the two organizations that could help avoid deep-end services; 3) identification of opportunities to conduct common marketing and provide information in a coordinated way; and 4) share customer, outcomes, and program and services data between the two organizations. Co-leads were identified at the May 27th meeting to move collaboration goals forward.

The Department of Juvenile Justice (DJJ) provides supervision, detention, a range of treatment and education services for youths referred to DJJ by the Juvenile Courts, and provides assistance or delinquency prevention services for at-risk youth through collaborative efforts with other public, private, and community entities. Over 52,000 youth are served annually, including

youth who are placed on probation, sentenced in short-term incarceration, or committed to DJJ's custody by Juvenile Courts. DJJ, Corrections, Pardons and Parole, and MCH work collaboratively to strengthen relationships and create a continuum of care for youth leaving the state's youth detention centers to address their need for community-based health and mental health services.

The Department of Labor (DOL) operates five integrated and interdependent programs that share a primary goal -- to help people with disabilities become fully productive members of society by achieving independence and meaningful employment. The largest of the programs are the Vocational Rehabilitation (VR) Program, Disability Adjudication Services, and the Roosevelt Warm Springs Institute for Rehabilitation. Two other programs serve consumers with visual impairments, the Business Enterprise Program and Georgia Industries for the Blind.

The Governor's Office for Children and Youth (GOCF) mission is to build capacity in communities to improve outcomes for Georgia's children, youth and families. GOCF was created in 2008 to ensure that Georgians are using child welfare resources -- funding, policy, and personnel -- in a way that is targeted, consistent, and most effective. This initiative united the Children's Trust Fund Commission (CTFC), Children and Youth Coordinating Council (CYCC), Office of the Child Advocate, and Office of Child Fatality Review in the newly organized GOCF.

GOCF supports and strengthens families and improves outcomes for Georgia's children and youth through a community-based system of prevention and intervention services, known as Caring Communities for Children and Families. The Caring Communities system of care approach integrates care planning and management through partnerships with community organizations, children, youth and families. Organizations work in partnership to develop a network in which children, youth and families can access the programs and services that meet their needs.

GOCF is leading Partnerships for Healthy Communities, an interagency collaborative project supported by the University of North Carolina at Chapel Hill's PREVENT Institute. In addition to GOCF, partner agencies include DFCS and Children's Healthcare of Atlanta. Partnerships for Healthy Communities seeks to decrease the rate of physical abuse and abuse related injuries in Georgia's children from infancy to three years of age. To accomplish this, Partnerships for Healthy Communities is assisting health-care providers -- including pediatricians, family practice physicians, and their staff -- in preventing, recognizing and reporting physical and sexual abuse as well as neglect.

GOCF, in partnership with DECAL, leads Strengthening Families Georgia (SF), an interagency collaborative project that seeks to create a child abuse and neglect prevention initiative that can help program developers, policymakers and advocates embed effective prevention strategies into existing systems. The project uses the Strengthening Families assets-based framework of protective factors in all systems, programs, services and activities supporting families with young children.

The Social Security Administration, Rehabilitation, and Disability Unit contracts with the DOL Office of Rehabilitation Services for state disability adjudication services and determines the eligibility of children birth to age 21 for Supplemental Security Income (SSI).

MATERNAL AND CHILD HEALTH PARTNERS IN GEORGIA:

There are a number of advocacy, service, and professional organizations in Georgia that are working to improve outcomes for the state's women, infants, children, and children with special health care needs. Brian Castrucci, who joined DPH in January 2010 as the new MCH Director/Title V MCH Block Grant Director, and his staff are working to engage the state's MCH stakeholders and identify opportunities for collaboration. (See the Georgia 2010 Title V MCH Block Grant Five Year Needs Assessment for a summary of a focus group held on March 18, 2010 with MCH stakeholders to provide input on the critical health and healthcare needs for

Georgia's MCH populations.) Several key maternal, child, and family partnerships in the state are highlighted below. A more in-depth description of partners and stakeholders is provided in the Needs Assessment.

The Family Connection Partnership is a public/private partnership created by the State of Georgia and funders in the private sector to help communities address the serious challenges facing Georgia's children and families. As a nonprofit intermediary organization, the Partnership works closely with community, state, and national partners to provide training and technical assistance to Family Connection county collaboratives; enhances public awareness, understanding, communication, and commitment to improve results for children and families; and uses research and evaluation to promote effective practices and programs. Family Connection serves on the ECCS Steering Committee and on the ECCS Planning Committee.

The Georgia Children's Health Alliance (GCHA) is a statewide collaboration uniting public, private, not-for-profit, business sectors, and pediatric health experts to create healthier futures for Georgia children. Children's Healthcare of Atlanta (CHOA), March of Dimes, and Prevent Child Abuse Georgia serve as the lead agencies for GCHA. In 2009, GCHA and DPH joined together to lead the development of the 2010 "REFOCUS on Child Health in Georgia" report. The purpose of the report, which was released in April 2010, is to: 1) establish a baseline showing where the health of Georgia's children is today and create a starting point for conversations about child health issues, and 2) highlight what data are missing or need improvement and to bring organizations together to work on filling those data gaps. The report not only highlights health issues facing Georgia, but also looks at obstacles to families, individuals, health professionals, and organizations that are looking to improve health outcomes for Georgia's children. In addition to the report, GCHA is leading implementation of the SHAPE act to track fitness levels in school children and improve those levels as well as supporting curriculum in child care centers promoting healthy eating and physical activity. GCHA also supports reduction in child abuse and neglect through parent interventions and evaluation of home visitation models.

The Georgia Early Childhood Comprehensive Systems (ECCS) Initiative Steering Committee is composed of key early childhood partners across the state. Funded by a grant from the federal Maternal and Child Health Bureau, Initiative activities include the development of two electronic survey tools to: 1) assess the current and potential contributions of existing ECCS partners related to each of the five ECCS component areas (medical and dental home, social emotional development of young children, early care and education, parenting education, and family support) and system capacity building potential and 2) identify public and private early childhood developmental screening practices and social emotional program systems capacity at the local level. Partnerships have been developed with the Centers for Disease Control and Prevention (CDC) "Learn the Signs, Act Early" State Team and with KidsNet Georgia. A medical/dental home brochure is in the final stage of development to be used with families and non-medical early childhood case managers.

Healthy Mothers, Healthy Babies Coalition of Georgia (HMHB) is a strong, statewide voice for improved access to healthcare and improved maternal and child health outcomes through a statewide network of grassroots advocates. HMHB operates the PowerLine, Georgia's toll-free, bilingual helpline for healthcare referrals funded by the MCHP. The PowerLine maintains a database of Georgia's low-cost and sliding-scale providers, free clinics, public health program such as Babies Can't Wait, and community health services. They also refer callers to appropriate WIC Clinics and record reports of complaints or fraud.

Parent to Parent of Georgia is a statewide agency that serves children and youth with disabilities and their families. Parent to Parent offers an on-line data base of various resources such as child care, respite care or support groups that are available in local areas, provides parent-to-parent matching service, training sessions for parents on a wide variety of topics and assist local areas in organizing parent support groups. Parent to Parent of Georgia is a free service and is funded in part by DPH.

Voices for Georgia's Children is an independent, non-profit organization whose mission is to substantially improve the state's low "Kids Count" child well-being ranking by engaging lawmakers and the public in building a sustained, comprehensive, long-term agenda to impact the lives of Georgia kids in five distinct areas: health, safety, education, connectedness and employability. Through advocacy, research and analysis, Voices address three strategic priorities: 1) a long term policy agenda for children; 2) expanding and educating leadership for children; and 3) building public will to improve child well-being.

RELEVANT COUNCILS:

The Governor's Council on Developmental Disabilities (DD Council) serves as an advisory body and provides broad policy advice and consultation to state agencies.

The Interagency Coordinating Council (ICC) for Early Intervention, mandated under Part C of IDEA, is appointed by the Governor to advise and assist DCH in planning, coordinating and implementing a statewide system of early intervention services for children with or at risk for developmental delays.

Federal Qualified Centers: Georgia's Community Health Centers (CHCs) offer a comprehensive range of primary health care and other services including around the clock care, acute illness treatment, prenatal care, well-child care, physicals, preventive services, health education, nutritional counseling, laboratory, x-ray and pharmacy services. The state's network of 28 CHCs serves over 238,000 Georgians each year in over 70 of the state's 159 counties. A number of these CHCs provide perinatal case management services and newborn follow-up.

Tertiary Care Facilities: Relationships have been established throughout the state with tertiary care facilities with technical resources that have enhanced Georgia's capacity to offer services to women of childbearing age, infants, children and adolescents. The state has two Level II pediatric trauma centers, four children's hospitals, and two burn units. Regional perinatal services are provided statewide through six designated tertiary care hospitals located in Atlanta, Macon, Augusta, Columbus, Albany and Savannah. High-risk perinatal services provided include transportation, prenatal care, delivery, post-partum care, and newborn care. A regional perinatal planning process facilitates planning in each of the six perinatal regions, bringing together in each region representatives from hospitals, district public health, and community organizations.

Technical Resources: The MCH Program collaborates with the state's Distance Learning and Telemedicine Program (GSAMS) network to bring specialty health care to areas with limited access. BCW also utilizes telehealth technology. All four of the state's medical schools (Medical College of Georgia, Emory University School of Medicine, Morehouse School of Medicine, and Mercer University School of Medicine) have faculty that participate in the CMS program. The Centers for Disease Control and Prevention (CDC) is a valuable resource in providing technical assistance and resources to the Program. The Rollins School of Public Health at Emory University works with DPH in many areas: internships for students; program and outcome evaluation; and technical assistance and consultation. Several other universities (Georgia State University, University of Georgia, and Clayton State) also work with MCH and DPH, providing technical assistance, research, and training. Georgia State University's Health Policy Center (GHPC) conducts, analyzes and disseminates qualitative and quantitative findings to connect decision makers, including DPH and its MCH Program, with the objective research and guidance needed to make informed decisions about health policy and programs. The GHPC is working with DCH on a low birth weight modeling project which dovetails with work on the Planning for Healthy Babies (P4HB) Medicaid waiver that will extend eligibility for family planning services to low income women.

Professional Organizations: MCH works on an ongoing basis with the Medical Association of Georgia, Georgia State Medical Association, Georgia Chapter of the American Academy of

Pediatrics (GA-AAP), Georgia Academy of Family Physicians (GAFF), Georgia Chapter of the College of Obstetrics and Gynecology, and other professional groups to promote increased private sector involvement in serving women, children, and youth in need.

A more in-depth description of Georgia MCHP partners is provided in the Needs Assessment.

F. Health Systems Capacity Indicators

Introduction

The Health System Capacity Indicators identify opportunities to strengthen health care system in Georgia through improved collaboration between Medicaid and Georgia Title V. Health System Capacity Indicators 2, 3, 5A through D, 6A through C, 7A, and 7B are all associated with Medicaid. As described in this section, there are several MCH programs that support Medicaid enrollment and linkage to service. Improved collaboration between Medicaid and Georgia Title V may result in improvements in these indicators.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	32.3	32.3	20.6	22.7	21.1
Numerator	2236	2236	1522	1684	1610
Denominator	692726	692726	737422	740521	763751
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009

Data are unavailable for 2008 and 2009. The provisional estimates are developed using a linear projection with data from 2000 through 2007. Population data provided by the Georgia Online Analytic Statistical Information System. Population data for 2009 are estimated using a linear projection with data from 2000 through 2008.

Data were updated for 2007, 2008, and 2009

Narrative:

The Georgia Asthma Control Program (GACP) is part of a national initiative launched by the Centers for Disease Control and Prevention (CDC), National Center for Environmental Health to reduce the burden of asthma and improve the health and quality of life for all persons affected by asthma through effective control of the disease. DPH established the Georgia Addressing Asthma from a State Perspective (GAASP) in 2001 with CDC funding. GAASP, led by DPH, includes representation from more than 30 organizations, including academic institutions, advocacy groups, professional organizations, private and public health care centers, and a private foundation.

Children's Medical Service Program Coordinators in all 18 public health districts provide asthma education to children with asthma and their families. Education topics include recognition and

avoidance of triggers in the home and in a child's environment; recognition of signs of distress and a plan of action; identifying signs of distress and importance of alerting an adult when away from home; the importance of having an asthma action plan; and the relationship of obesity to asthma. The CMS Coordinators also provide asthma education to school nurses that emphasizes avoidance of triggers and asthma management with the use of a child's asthma action plan. Some districts provide funding for tuition for asthma camps, such as Camp Breathe Easy or Camp Huff and Puff, or they sponsor the camp in their district.

The GACP has provided funding to support asthma education efforts in seven health districts and their communities. GACP also partners with local health districts to promote the adoption of "Asthma Friendly School" policies. Through these partnerships, GACP targets school age children and the birth to four age population.

GACP has an active statewide coalition, the Georgia Asthma Advisory Council, composed of over 45 medical and public health professionals, business and government agency leaders, community activities, and others dedicated to improving the quality of life for people with asthma through information-sharing, networking, and advocacy. The coalition is chaired by one of the directors of the Area Health Education Center (AHEC). Key stakeholders, such as the Healthcare Georgia Foundation and their asthma grantees, which include Children's Healthcare of Atlanta (CHOA), GASN, Galilee Outreach Ministry, Inc, and Area Health Education Centers (AHEC) are now GAAC members. The addition of these organizations to the GAAC membership has expanded the reach of GACP.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	71.7	77.2	88.0	100.0	85.9
Numerator	154202	150013	93568	105590	86472
Denominator	214929	194261	106361	105590	100682
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009

Data source is CMS-416. For children under the age of 1 year, data on CMS-416 used in this measure are from row #1 and row #9 totals. Data for 2007, 2008, and 2009 were updated.

Notes - 2008

These data exclude all CMO data. CMO plans were implemented in June 2006. Counts may be lower than expected from this period forward.

Notes - 2007

These data exclude all CMO data. CMO plans were implemented in June 2006. Counts may be lower than expected from this period forward.

Narrative:

Eligible Medicaid children and PeachCare enrolled children are matched with one of three Georgia Healthy Families Care Management Organizations (CMOs): Amerigroup Community Care, Peach State Health Plan, and WellCare. The MCH Program supports and assists children and families enroll in Medicaid. This indicator is supported by the MCH Program through Children 1st and Health Check.

Children 1st is the "Single Point of Entry" to a statewide collaborative system of public health and other prevention based programs and services. This system helps parents provide their young children with a healthy start in life. It allows at-risk children to be identified early and gives them a chance to grow up healthy and ready for school. Participation is voluntary and there are no financial requirements for enrollment into the program. Children 1st may assist Medicaid-eligible children access needed services.

Health Check is Georgia's well child or preventive health care program for Medicaid-eligible children birth to 21 years of age and PeachCare for Kids™-eligible children birth to 19 years of age. It is the Early and Periodic Screening, (EPS) component of the EPSDT program for the State of Georgia. The Diagnostic and Treatment (DT) service components are provided by either the Health Check screening provider, if qualified to perform those services, or upon referral to an appropriate service provider of the member's choice.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	63.2	60.5	57.5	50.6	74.3
Numerator	1707	1711	1069	533	961
Denominator	2702	2828	1859	1054	1294
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009

Data provided by the Division of Medical Assistance in the Department of Community Health.

Report is based on members who were eligible during FFY09.

Patient reports are based on claims incurred during Federal Fiscal Year 2009 (Oct 08 - Sept 09) and paid through March 2010.

Report excludes all CMO data. CMO plans were implemented in June 2006 therefore counts may be lower than expected from this time period forward.

PeachCare members/patients on this report are Fee For Service.

Reports run in Medstat, Decision Analyst May 2010.

Notes - 2008

Data provided by the Division of Medical Assistance in the Department of Community Health.

Report is based on members who were eligible during FFY09.

Patient reports are based on claims incurred during Federal Fiscal Year 2009 (Oct 08 - Sept 09) and paid through March 2010.

Report excludes all CMO data. CMO plans were implemented in June 2006 therefore counts may be lower than expected from this time period forward.

PeachCare members/patients on this report are Fee For Service.

Reports run in Medstat, Decision Analyst May 2010.

Notes - 2007

Data provided by the Division of Medical Assistance in the Department of Community Health.

Report is based on members who were eligible during FFY09.

Patient reports are based on claims incurred during Federal Fiscal Year 2009 (Oct 08 - Sept 09) and paid through March 2010.

Report excludes all CMO data. CMO plans were implemented in June 2006 therefore counts may be lower than expected from this time period forward.

PeachCare members/patients on this report are Fee For Service.

Reports run in Medstat, Decision Analyst May 2010.

Narrative:

Eligible PeachCare for Kids children are matched with one of three Georgia Healthy Families Care Management Organizations (CMO) (Amerigroup Community Care, Peach State Health Plan, and WellCare).

The MCH Program supports and assists children and families enroll in Medicaid. This indicator is supported by the MCH Program through Children 1st and Health Check.

Children 1st is the "Single Point of Entry" to a statewide collaborative system of public health and other prevention based programs and services. This system helps parents provide their young children with a healthy start in life. It allows at-risk children to be identified early and gives them a chance to grow up healthy and ready for school. Participation is voluntary and there are no financial requirements for enrollment into the program. Children 1st may assist Medicaid-eligible children access needed services.

Health Check is Georgia's well child or preventive health care program for Medicaid-eligible children birth to 21 years of age and PeachCare for Kids™-eligible children birth to 19 years of age. It is the Early and Periodic Screening, (EPS) component of the EPSDT program for the State of Georgia. The Diagnostic and Treatment (DT) service components are provided by either the Health Check screening provider, if qualified to perform those services, or upon referral to an appropriate service provider of the member's choice.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	68.9	68.9	49.8	56.3	54.0
Numerator	97082	97082	74888	85040	83064
Denominator	140903	140903	150297	151032	153768
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009

In 2007, Georgia adopted the 2003 Revised Birth Certificate part way through the year. This had two impacts on HSCI 04. First, it changed how the entry into prenatal care question was asked from asking for month of entry into prenatal care to asking for date of entry into prenatal care. Second, the vitals reporting system changed. The impact of the first change is well described by NCHS. The impact of the second change was that the percent of women with unknown entry into prenatal care increased beyond what would be expected to happen from the wording change alone. In 2007, 25.8% of women were missing information necessary for calculating the Kotelchuck Index.

The reported percentages use total births to women 15 to 44 years of age. If limited to only those births for which there are valid data, the reported percent would be 68.2% compared to 49.8%.

Data are unavailable for 2008 and 2009. The provisional estimates are developed using a linear projection with data from 2000 through 2007.

Data were updated for 2007, 2008, and 2009.

Narrative:

The MCH Program continues outreach efforts to increase access to prenatal care and referrals to prenatal providers during the first trimester of pregnancy. Referrals to providers that offer low-cost or no-cost prenatal care for uninsured and underinsured pregnant women also are made through PowerLine (Georgia's Title V toll-free number).

Through several MCH Programs, including WIC and Family Planning, educational messages are delivered that promote planned pregnancies and the importance of preconception health. These messages may contribute to earlier engagement in prenatal care.

With the implementation of the 2003 Certificate of Live Birth in 2007, questions used to measure prenatal care initiation and visits changed. This change is seen in the approximately 20 percentage point drop in this indicator between 2006 and 2007.

From PRAMS data, the percent of women who received prenatal care in the first trimester remained consistent between 2004 and 2006. This indicator falls short of the Healthy People 2010 objective of 90 percent. Women with more than a high school diploma came closest to reaching the Healthy People 2010 objective. The percent of women who received prenatal care in the first trimester was less than 60 percent among women under the age of 20 years, Hispanic women, and women with less than a high school diploma. In half of Georgia's public health districts, between 80 percent and 89 percent of women received prenatal care in the first

trimester. The Clayton Public Health District was the only district to have fewer than 75 percent of women receive prenatal care in the first trimester.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	81.1	80.8	40.5	45.2	43.2
Numerator	875228	846040	432843	479182	494864
Denominator	1078849	1046926	1069682	1059612	1146385
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009

Data source is CMS-416. CMS-416 used in this measure are from row #1 and row #9 totals (all ages). Data for 2007, 2008, and 2009 were updated.

Notes - 2008

This data excludes all CMO data. CMO plans were implemented in June 2006 and therefore, counts maybe be lower than expected from this period forward.

Notes - 2007

This data excludes all CMO data. CMO plans were implemented in June 2006 and therefore, counts maybe be lower than expected from this period forward.

Narrative:

With implementation of Georgia's Medicaid managed care system and the family's choice of a CMO, the PCP member of the selected CMO is the child's "medical home." Each of the state's three Medicaid Care Management Organization (CMO) providers have a different agreement for services traditionally provided by the state's 159 county health departments. MCH staff work to educate families new to Medicaid managed care process to assist them in navigating the services and regulations of a Care Management Organization (CMO).

The MCH Program supports and assists children and families enroll in Medicaid. This indicator is supported by the MCH Program through Children 1st and Health Check.

Children 1st is the "Single Point of Entry" to a statewide collaborative system of public health and other prevention based programs and services. This system helps parents provide their young children with a healthy start in life. It allows at-risk children to be identified early and gives them a chance to grow up healthy and ready for school. Participation is voluntary and there are no financial requirements for enrollment into the program. Children 1st may assist Medicaid-eligible children access needed services.

Health Check is Georgia's well child or preventive health care program for Medicaid-eligible

children birth to 21 years of age and PeachCare for Kids™-eligible children birth to 19 years of age. It is the Early and Periodic Screening, (EPS) component of the EPSDT program for the State of Georgia. The Diagnostic and Treatment (DT) service components are provided by either the Health Check screening provider, if qualified to perform those services, or upon referral to an appropriate service provider of the member's choice.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	51.4	47.3	57.2	67.4	57.1
Numerator	173685	112068	115873	134826	126043
Denominator	337979	236724	202535	200066	220652
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009

Data source is CMS-416. For children between the ages of 6 and 9 years, data on CMS-416 used in this measure are from row #1 and row #12a totals. Data for 2007, 2008, and 2009 were updated.

Notes - 2008

This data excludes all CMO data. CMO plans were implemented in June 2006 and therefore, counts maybe be lower than expected from this period forward.

Notes - 2007

This data excludes all CMO data. CMO plans were implemented in June 2006 and therefore, counts maybe be lower than expected from this period forward.

Narrative:

The MCH Oral Health Section (OHS) and the district Georgia Oral Health Prevention Program (OHP) provide dental services to underserved school children by targeting schools with greater than 50% free and reduced lunch program participants. Services at targeted schools include screenings or examinations, sealants, fluoride applications, preventive educational services, and fluoride mouth rinse programs when appropriate. The Oral Health district programs include 33 fixed clinic sites and 14 mobile dental units in 11 health districts. OHP maintains a list of referral sources that accept Medicaid and PeachCare reimbursements, including public health facilities and sliding scale community centers for children needing more extensive dental care.

Population based services continue with a strong focus on prevention and collaboration with other medical providers. Expansion of the Medical college of Georgia School of Dentistry and HRSA workforce development grant provides more public health internships to senior dental students. Planning has begun to lay the framework for the fall 2010 3rd grade survey. Eighty schools have been randomly selected by the OH Epidemiologist. To ensure reliable and valid data survey forms are being developed and pre-evaluated by the Epidemiologist. Opportunity for input on the 3rd grade survey was open to the Obesity and Nutrition Units. Questions developed by these units and a BMI will be included in the survey to support the initiatives of these programs. A

search for a consultant to train the health care professionals doing the surveying has begun.

Significant inequalities in oral health remain in the U.S. based on income, race/ethnicity, disability and geographic location. Participation by staff in numerous outreach programs for children needing oral health services promotes the program and helps reach children presenting with these disparities. In 2009, the staff helped plan (and participated in as a provider) the Public Health- GDA collaboration for "Give Kids-A Smile" Day in Toombs County in Feb 2009. Over 120 children with limited access to dental care were provided comprehensive dental services. In February, 2010, staff participated in "Give Kids-A-Smile Day along with Georgia Perimeter College dental hygiene students and DeKalb Health department dental staff, and the Georgia Dental Association, with 842 participants, 244 sealants were placed, 175 fluoride varnish applications and other dental services. This was a school selected due to language barriers and the percentage of free lunch kids. With two OHU staff members bilingual in Spanish these children felt extra comfortable with the staff. Two staff members volunteered for the Baptist Mobile Dental Van serving a Spanish population in the Decatur area. Patients were treated by staff members as they volunteered their services.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	7.1	6.9	5.8	5.0	4.8
Numerator	2019	2056	1987	1794	1784
Denominator	28487	29741	34355	35538	37131
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

Notes - 2009

The source for the denominator was SSI Recipients by State and County, 2009, 2008, and 2007 (http://www.ssa.gov/policy/docs/statcomps/ssi_sc/). This source provides SSI recipients less than 18 years of age. The number of recipients less than 16 years of age was estimated by applying the proportion of children 16 years of age and younger in the Georgia population to the number of recipients less than 18 years of age. Population data are available for 2007 and 2008. 2008 population data were used for the 2009 estimate. For 2007 and 2008, the percent of children 16 years of age or younger among all children younger than 18 years of age was 94.6%.

The source for the numerator is Children's Medical Services program data.

Data were updated for 2007, 2008, and 2009.

Narrative:

The MCH Program, through Children's Medical Services, assists families of CSHCN in identifying and accessing insurance resources. Educational sessions have been provided to Health District Coordinators on Medicaid (i.e., Right from the Start Medicaid, Emergency Medicaid, Deeming Waiver and Medically Needy Spend Down). The range of SSI beneficiaries varies greatly by health district. This indicator is monitored using district quarterly reports.

Health Systems Capacity Indicator 05A: Percent of low birth weight (< 2,500 grams)

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2005	matching data files	9.8	8.2	9.1

Notes - 2011

Data are from 2004 linked Medicaid/birth record file.

TVIS requires a year be entered. With 2004 not an available option, 2005 was selected.

Due to the loss of a Medicaid contract, we no longer receive Medicaid delivery claims files and therefore cannot link Medicaid delivery claims with Birth certificates. 2004 is the most current linkage available.

Beginning with the 2008 birth cohort, payment source will be available on the birth record. The birth record will be the source of these data until the practice of linking the Medicaid files to the birth record is re-initiated.

Narrative:

Georgia's Perinatal Regional System provides funding through the Department of Community Health to six designated regional tertiary hospitals to provide high-risk perinatal services, including transportation, prenatal care, delivery, post partum care, and newborn care. Tertiary hospitals also provide outreach and education to area providers to further a seamless community-based system in Georgia. Women who are at or below 250% of federal poverty level are eligible for funding of these services.

In April 2009, DCH, in collaboration with community and agency partners, embarked on an initiative, Planning for Healthy Babies (P4HB), to reduce Georgia's low birth weight rate from 9.5% to 8.6% over a five year time span. Currently, the Georgia Medicaid Program provides prenatal coverage for pregnant women with monthly incomes at or below 200 percent of the FPL. These women are eligible for family planning services through the end of the month in which the 60th postpartum day falls. After 60 days, women whose incomes exceed the categorical limits for participation in the traditional Medicaid program lose eligibility for all benefits, including family planning. Implementation of the P4HB program will extend eligibility for family planning services to women aged 18 through 44 years who are at or below 200 % of the most current FPL; and provide inter-pregnancy care to women at or below 200% of poverty who have previously delivered a very low birth weight baby. The waiver will begin in January 1, 2011 and end December 31, 2015.

Health Systems Capacity Indicator 05B: Infant deaths per 1,000 live births

INDICATOR #05 <i>Comparison of health system capacity</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL

indicators for Medicaid, non-Medicaid, and all MCH populations in the State					
Infant deaths per 1,000 live births	2005	matching data files	9.6	7.4	7.9

Notes - 2011

Data are from 2004 linked Medicaid/birth record file.

TVIS requires a year be entered. With 2004 not an available option, 2005 was selected.

Due to the loss of a Medicaid contract, we no longer receive Medicaid delivery claims files and therefore cannot link Medicaid delivery claims with Birth certificates. 2004 is the most current linkage available.

Beginning with the 2008 birth cohort, payment source will be available on the birth record. The birth record will be the source of these data until the practice of linking the Medicaid files to the birth record is re-initiated.

Narrative:

MCH Epidemiology conducts analyses of infant deaths to identify groups at highest risk and to identify risk factors that may be potentially modifiable. Results from these analyses are being used to target intervention efforts in communities with the highest rates of infant death and to focus efforts on effective interventions.

Finding Opportunities through Collaboration, Understanding, and Science (FOCUS), a state and local public health partnership to address Georgia's infant mortality rates and poor birth outcomes, is facilitating community-oriented, data-driven, and system focused planning processes at the local level. Key data include an analysis of Perinatal Periods of Risk data and mapping of incidence of fetal and infant mortality in some of the counties with the state's highest rates and numbers of infant mortality.

The MCH Program's Perinatal/Women's Health Unit is working with MCH Epidemiology to establish a Maternal Pregnancy Associated Mortality Review Committee.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2005	matching data files	76.7	91.8	83.3

Notes - 2011

Data are from 2004 linked Medicaid/birth record file.

TVIS requires a year be entered. With 2004 not an available option, 2005 was selected.

Due to the loss of a Medicaid contract, we no longer receive Medicaid delivery claims files and therefore cannot link Medicaid delivery claims with Birth certificates. 2004 is the most current linkage available.

Beginning with the 2008 birth cohort, payment source will be available on the birth record. The birth record will be the source of these data until the practice of linking the Medicaid files to the birth record is re-initiated.

Narrative:

Medicaid. Early and adequate prenatal care is encouraged and supported through MCH and Medicaid case management programs. Delivery of high risk infants at centers that are appropriate for their needs is encouraged through education efforts conducted by outreach educators in their perinatal region.

The MCH Program's Perinatal/Women's Health Unit is collaborating with the Division of Medical Assistance and public health districts to increase the percentage of women with early entry into prenatal care. Program staff are also working with Healthy Start grantees and other community stakeholders to improve services for pregnant women in Georgia.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2005	matching data files	67	80.3	68.4

Notes - 2011

Data are from 2004 linked Medicaid/birth record file.

TVIS requires a year be entered. With 2004 not an available option, 2005 was selected.

Due to the loss of a Medicaid contract, we no longer receive Medicaid delivery claims files and therefore cannot link Medicaid delivery claims with Birth certificates. 2004 is the most current linkage available.

Beginning with the 2008 birth cohort, payment source will be available on the birth record. The birth record will be the source of these data until the practice of linking the Medicaid files to the birth record is re-initiated.

Narrative:

MCH programs link patients with available programs and entitlements for which they are eligible to support the delivery of MCH services. As soon as a pregnancy is identified, eligible women are linked to Medicaid. Early and adequate prenatal care is encouraged and supported through MCH and Medicaid case management programs. Delivery of high risk infants at centers that are appropriate for their needs is encouraged through education efforts conducted by outreach educators in their perinatal region.

MCH works collaboratively with the Georgia Association of Family Practitioners (GAFP) and the Georgia Chapter of the OB/GYN Society to encourage linkage of pregnant women to early and adequate prenatal care. The Powerline, operated by Healthy Mothers Healthy Babies provides women with referral and contact information for low cost obstetrical providers. The MCH also provides public health awareness and education based on CDC's recommended guidelines on preconception health, including encouraging women to make healthy lifestyle changes and to develop a reproductive life plan with their providers, in an effort to improve birth outcomes.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Infants (0 to 1)	2009	200
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Infants (0 to 1)	2009	235

Notes - 2011

Eligibility information can be found at
http://dch.georgia.gov/00/channel_title/0,2094,31446711_31945377,00.html.

Notes - 2011

Eligibility information can be found at
<http://www.healthinsurancefinders.com/healthinsurance/georgia/schip.html>.

Narrative:

Georgia Medicaid is funded through \$2,370,000,000 in state funds and \$4,448,000,000 in federal funds. Georgia Medicaid serves 1.69 million clients, of which approximately half (823,000) are children. Of all Medicaid spending in Georgia, 30 percent is expended on children compared to 20.5 percent nationally. Georgia Medicaid expends approximately \$2,000 per child compared to \$2,135 nationally. Medicaid spending declined 8.7 percent in Georgia, while increasing nationally by 3.6 percent.

Medicaid pays for approximately 60 percent of all deliveries in Georgia. There is no SCHIP support for pregnant women. A to-be-implemented family planning waiver in Georgia will expand postpartum coverage to a greater number of women to improve birth outcomes and spacing.

PeachCare for Kids, the name for Georgia CHIP, is funded through \$77,965,510 in state funds and \$224,990,270 in federal funds. The PeachCare for Kids enrollment in June 2009 was 198,951 children. The greatest enrollment was June 2007 with 276,551 enrolled.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Medicaid Children (Age range 1 to 5) (Age range 6 to 19) (Age range to)	2009	133 100
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Medicaid Children (Age range 1 to 19) (Age range to) (Age range to)	2009	235

Notes - 2011

Eligibility ends on the day prior to the 19th birthday.

Eligibility information can be found at

http://dch.georgia.gov/00/channel_title/0,2094,31446711_31945377,00.html.

Notes - 2011

Eligibility ends on the day prior to the 19th birthday.

Eligibility information can be found at

<http://www.healthinsurancefinders.com/healthinsurance/georgia/schip.html>.

Narrative:

Georgia Medicaid is funded through \$2,370,000,000 in state funds and \$4,448,000,000 in federal funds. Georgia Medicaid serves 1.69 million clients, of which approximately half (823,000) are children. Of all Medicaid spending in Georgia, 30 percent is expended on children compared to 20.5 percent nationally. Georgia Medicaid expends approximately \$2,000 per child compared to \$2,135 nationally. Medicaid spending declined 8.7 percent in Georgia, while increasing nationally by 3.6 percent.

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Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
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Pregnant Women	2009	200
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Pregnant Women		

Notes - 2011

Eligibility information can be found at

http://dch.georgia.gov/00/channel_title/0,2094,31446711_31945377,00.html.

Notes - 2011

Pregnant women are not eligible to receive SCHIP in Georgia.

Eligibility information can be found at

<http://www.healthinsurancefinders.com/healthinsurance/georgia/schip.html>.

Narrative:

Georgia Medicaid is funded through \$2,370,000,000 in state funds and \$4,448,000,000 in federal funds. Georgia Medicaid serves 1.69 million clients, of which approximately half (823,000) are children. Of all Medicaid spending in Georgia, 30 percent is expended on children compared to 20.5 percent nationally. Georgia Medicaid expends approximately \$2,000 per child compared to \$2,135 nationally. Medicaid spending declined 8.7 percent in Georgia, while increasing nationally by 3.6 percent.

Medicaid pays for approximately 60 percent of all deliveries in Georgia. There is no SCHIP support for pregnant women. A to-be-implemented family planning waiver in Georgia will expand postpartum coverage to a greater number of women to improve birth outcomes and spacing.

PeachCare for Kids, the name for Georgia CHIP, is funded through \$77,965,510 in state funds and \$224,990,270 in federal funds. The PeachCare for Kids enrollment in June 2009 was 198,951 children. The greatest enrollment was June 2007 with 276,551 enrolled.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
<u>ANNUAL DATA LINKAGES</u> Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	2	No
Annual linkage of birth certificates and WIC eligibility files	2	No

Annual linkage of birth certificates and newborn screening files	3	Yes
<u>REGISTRIES AND SURVEYS</u> Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	Yes
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2011

Narrative:

DPH has implemented the Online Analytical Statistical Information System (OASIS), a suite of tools used to access the standardized health data repository. The standardized health data repository is currently populated with vital statistics, hospital discharge data, emergency room data, Georgia Comprehensive Cancer Registry, and population data. Youth Risk Behavior Survey data is also available by year, school level, and survey category.

The MCH Epidemiology Section annually links major data sets including infant birth and death certificates, birth certificates to Medicaid and WIC data, and birth certificates to Newborn Screening data. These linked sets are critical to evaluating MCH programs and providing data for surveillance and monitoring of the health status of the MCH population. Data from Georgia's statewide birth defects surveillance system are used for surveillance and monitoring of birth defects and to ensure children with birth defects are identified through the Children 1st system.

MCH Epi conducts the Pregnancy Risk Assessment Monitoring System (PRAMS). PRAMS data are used to monitor the Georgia's performance on issues such as breastfeeding, prenatal care experiences, and how babies are put to bed.

Survey of Perinatal Capacity:

Georgia is a state where perinatal levels are self designated, as documented on the initial Certificate of Need. No follow-up inspections of capacity occur unless a complaint is lodged with the state. To determine the current capacity, evaluate self-designation against TIOP II classification and infant and maternal outcomes, a survey has been developed. The survey, developed in collaboration with Emory University and with input from state and national experts, is currently being field tested in one of the state's perinatal regions.

Alternate Measures of Inappropriate Delivery:

At the state and regional level, self designation and non-standard designation is a barrier to identifying inappropriate delivery. The MCH program is working at a state and regional level to identify alternative measures. An alternative to using perinatal level designation is to use volume - one of the strongest associations with decreased risk of neonatal death among very low birthweight deliveries is with volume of very low birthweight deliveries. Using the birth-infant death linked file, we examined the distribution of facility specific volume of <1,250 gram deliveries, and the associated day 0, early, and late neonatal mortality within volume deciles. We identified 2 cut points where a large shift in neonatal mortality was observed (<15 per year, 15-24 per year, and 25 or more per year). Next steps are to repeat for <1,000 grams and <1,500 grams. Georgia is

engaging regional partners in Mississippi and Kentucky to replicate this work to see if these cut-points are consistent across the region.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	Yes

Notes - 2011

Narrative:

The Youth Risk Behavior Surveillance System (YRBS) provides information on Georgia adolescents' tobacco use, including cigarette smoking, cigars, and smokeless tobacco. The state's annual federal Substance Abuse Mental Health Services Administration (SAMHSA) Synar Report provides an overview of tobacco youth enforcement activities in Georgia, including the number of tobacco enforcement investigations that resulted in the illegal sale of a tobacco product to an underage youth.

MCH staff have collaborated with the DPH Chronic Disease and Health Promotion/Tobacco Use Prevention Section and the Youth Empowerment Coordinator to provide collateral cessation messages and materials for tobacco and non-tobacco using youth. MCH has also collaborated with Chronic Disease Epidemiology to successfully implement and disseminate findings of the Youth Tobacco Survey in Georgia schools. Staff serve on the Tobacco-Free School work group, facilitated by the Youth DPH/Empowerment Coordinator.

The YRBS Survey is conducted in Georgia in odd calendar years to obtain information on risky behaviors, including tobacco use, among middle and high school students. The Youth Tobacco Survey, also conducted in odd years in Georgia, provides additional information on knowledge, attitudes, and beliefs related to tobacco and secondhand smoke exposure. Data collected from these surveys are used to review, redesign, and evaluate existing preventive programs. Survey findings are published and distributed to schools, district public health offices, stakeholders, and legislators and presented at public health conferences and meetings. Findings are also made publicly available on the DPH website.

IV. Priorities, Performance and Program Activities

A. Background and Overview

This current needs assessment and application occurred at a time of significant transition for the Georgia MCH Program. Within the twelve months prior to the submission of the FY 11 Title V MCH Services Block Grant, the Division of Public Health was reorganized into a different department, a new MCH Program Director was selected, and both the Title V MCH and CSHCN Directors changed. These changes coupled with the implementation of the needs assessment and an application at the start of a new five-year cycle presented challenges, but also significant opportunity. The Georgia MCH Program leadership capitalized on this opportunity by conducting a thorough analysis of existing quantitative data and collecting needed qualitative data from providers, advocates, and consumers throughout the state. These data provided the foundation for the identification and selection of the state's top priority needs. This process included significant involvement from the public, advocacy groups, statewide service organizations, professional societies, and state agencies. As described in Section B. State Priorities, most priority needs were aligned with national performance measures, others were addressed through the development of state performance measures or through activities linked to state and/or national performance measures. Section B also outlines the available capacity to address each priority measure. The success of this process is demonstrated, in part, by the public comments received pertaining to the needs assessment and selection of priority needs. Selected comments are provided below. All comments are included in the Attachment to I. General Requirements, E. Public Input.

"The data presented was thorough. It is great that the state involved many stakeholders."

"The process of this task was handled in a professional and efficient manner. It was well organized and included many stakeholders from private and public agencies."

"I am pleased to see Decrease Infant Mortality and Injury high on our list. I believe home visiting and parent education (as in Children 1st) to be the key to accomplishing this goal."

"I agree with the top 10 priority needs for Georgia mothers and children."

"I appreciate the very inclusive process used by MCH to help set priorities for Georgia."

"I am truly impressed with the new direction at the state office and am looking forward to making significant changes in the health outcomes of Georgia's maternal and child health population. The collaborations and partnerships that have been made and/or strengthened will be beneficial to Georgia's families."

"I agree with the top priority of decreasing our infant mortality rates."

"It appears that the strategies and approaches that you've come up with will eventually benefit all. There had to have been a lot of effort in orchestrating these processes. Job well done."

"I participated in the meetings held to select the 10 top priority needs for Georgia on June 3-4, 2010. I was impressed with the organization and method in which our groups worked to make these hard choices."

"I participated in the Title V Needs Selection Meeting in June 2010. I was very impressed with the focus group information presented, the 'real' grassroots process to identify the top ten priorities."

The MCH leadership also altered the activity planning and reporting process in FY11. In previous applications, Georgia Title V did not report on specific activities with the link between last year's accomplishments and the activities listed in Table 4a unclear. Beginning with the FY11

application, each year Georgia Title V will initiate a planning process that will involve partners and stakeholders to yield a specific activity plan for each national and state performance measure for the upcoming year that includes expected outcomes and a monitoring methodology. Progress on the FY11 annual activity plan will be reported under current activities in the FY12 application. In the FY13 application, the activities included in the FY11 activity plan will be reported under last year's accomplishments and each activity will be reflected in Table 4a. Reporting will be specific to each activity included in the plan compared to the current process of listing broad accomplishments that relate to the performance measure. The activity planning process will occur each year to develop an annual activity plan for each upcoming year. It is expected that each annual activity plan will build on the accomplishments of the previous year. By implementing this activity planning and reporting process beginning in FY11, Georgia Title V increases accountability for specific activities and increases the probability of impacting national and state performance measures by ensuring incremental improvements through successful completion of each activity.

B. State Priorities

Georgia's 2010 Needs Assessment submitted with the FY2011 Application identified nine priority needs. All state performance measures are associated with one or more of the nine priority needs. The pyramid levels, population groups, capacity to specific to the need, related national performance measures (NPMs) and state performance measures (SPMs), and the relationship between the need, NPMs, and/or SPMs is addressed for each need below.

Priority Need: Decrease infant mortality and injury

Pyramid Levels: Infrastructure building, Population based services, Enabling services, and Direct health care

Population Groups: Women and Infants

Capacity Specific to Need: There is significant capacity to address infant mortality and injury. To build infrastructure and understanding of infant mortality, capacity exists to perform detailed analyses of infant mortality at the county level including perinatal periods of risk analyses. Strategic coordination with WIC will allow the communication of messages to a high risk population. Through the Children 1st Program, very low birth weight infants receive home visiting follow-up care. By applying an algorithm to the electronic birth file, all infants born in Georgia are screened for socio-economic risk factors that may contribute to developmental delay or infant mortality. Through partnerships with the Georgia Chapter of the American Academy of Pediatrics, the Georgia Obstetrical and Gynecological Society, and Georgia Association of Family Physicians, strategies can be developed with the provider community that may include tailored messaging to clients. Through WIC and Title V, strong support for breastfeeding promotion also contributes to reducing infant mortality and injury. Developing partnerships with the Georgia Injury Prevention Program, Georgia Safe Infant Sleep Committee, and Georgia Child Death Review will strengthen and guide activity development to address this need.

Related NPMs and SPMs: NPMs 1, 10, 11, 15, 17 and SPMs 2, 7

Relationships between NPMs, SPMs, and Priority Needs: Several state and national performance measures contribute either directly or indirectly to addressing this priority need. SPM 2 is worded in a way that directly addresses this priority need. In response to SPM 2, activities can address such threats to infant health and survival as infant safe sleep, infant falls, and exposure to second hand smoke. SPM 7 and the NPMs listed each contribute indirectly to addressing this priority need. SPM 7 addresses the group at greatest risk for infant death by providing home visits to infants born weighing less than 1,500 grams. By identifying and providing follow-up for children who have failed a genetic screening, NPM 1 helps to ensure these children receive services

necessary to prevent possible infant death. Through NPM 10, infant mortality resulting from motor vehicle crashes can be addressed through greater use of infant safety seats. Breastfeeding through the first six months of life and beyond (NPM 11) is associated with decreased morbidity and increased immunity. Activities focused on reducing cigarette smoking in the third trimester (NPM 15) and throughout the entire pregnancy will help to reduce poor birth outcomes that can contribute to infant death. NPM 17 helps to ensure that high risk deliveries occur in an environment that best supports infants who may have complicating conditions.

Priority Need: Decrease obesity among children and adolescents

Pyramid Levels: Infrastructure building, Population based services, Enabling services

Population Groups: Children, Children with Special Health Care Needs

Capacity Specific to Need: Decreasing obesity among children and adolescents will require significant collaboration. The MCH Program has several opportunities to impact the obesity rate in early childhood through WIC. New legislation requiring all students to receive a fitness assessment has created an opportunity for collaboration between the Division of Public Health, Department of Education, and the Georgia Children's Health Alliance. These partners are working together to ensure that the information collected through the assessment can be used to strengthen existing surveillance and to target and evaluate health promotion interventions.

Related NPMs and SPMs: NPM 14, SPM 1

Relationships between NPMs, SPMs, and Priority Needs: SPM 1 is worded to directly address this priority need. The focus of the state performance measure is to reduce obesity among adolescents. However, interventions will need to be implemented prior to adolescence. The activity plan associated with SPM 1 will need to include activities in early and middle childhood and will need to address physical activity and nutrition. By contributing to reduced rates of obesity in early childhood, NPM 14 also contributes to success in meeting this priority need.

Priority Need: Reduce motor vehicle crash mortality among children ages 15 to 17 years

Pyramid Levels: Infrastructure building, Population based services

Population Groups: Children

Capacity Specific to Need: Capacity to address this need reside in the Division of Emergency Preparedness, Injury Prevention Program. The Injury Prevention Program can identify training and population-based messages to reduce the motor vehicle crash mortality through a variety of interventions.

Related NPMs and SPMs: SPM 4

Relationships between NPMs, SPMs, and Priority Needs: SPM 4 is worded to directly address this priority need.

Priority Need: Reduce repeat adolescent pregnancy

Pyramid Levels: Infrastructure building, Enabling services

Population Groups: Children

Capacity Specific to Need: Capacity exists within the MCH Program to analyze and produce annual reports on the prevalence of repeat adolescent pregnancies. Increased collaboration with

delivery hospitals and medical providers could lead to increased referrals for adolescent mothers to family planning services provided through the public health districts or Title X. Protocols can be developed between the WIC and the Family Planning Program to increase referrals and to ensure completion of referrals.

Related NPMs and SPMs: NPM 8

Relationships between NPMs, SPMs, and Priority Needs: This priority need will be addressed as an activity in NPM 8 activity plan.

Priority Need: Increase developmental screening for children in need

Pyramid Levels: Population based services, enabling services, direct health care

Population Groups: Children with special health care needs

Capacity Specific to Need: Through several MCH programs and improved collaboration, there is significant capacity available to address this need. The Part C Early Intervention Program (Babies Can't Wait), Children 1st, and Children's Medical Services all encounter children ages birth to five years of age. Additionally, discussions have occurred to develop plans to include developmental assessments throughout Georgia WIC clinics. Through existing partnerships with medical providers, the MCH Program can work to promote the need for every child in need to have appropriate developmental screening.

Related NPMs and SPMs: SPM 5

Relationships between NPMs, SPMs, and Priority Needs: SPM 5 is worded to directly address this priority need. While the focus of the need is all children, SPM 5 limits the denominator to those children who are encountered through MCH programs.

Priority Need: Improve the maternal and child health surveillance and evaluation infrastructure

Pyramid Levels: Infrastructure building

Population Groups: Women and infants, Children, Children with special health care needs

Capacity Specific to Need: The MCH epidemiology capacity in the MCH Program is increasing. As recommended in Maternal and Child Health Epidemiology in State Health Agencies: Guidelines for Enhanced Functioning, MCH Epidemiology was moved to be administratively located within the MCH Program in April 2010. The administrative change ensures seamless interaction between epidemiology and program staff. The newly created MCH Epidemiology Section includes a section director and nine full-time FTEs. With increased staffing, the MCH Epidemiology Section Director will work with stakeholders to understand their data needs and the existing data gaps.

Related NPMs and SPMs: SPM 3

Relationships between NPMs, SPMs, and Priority Needs: SPM 3 is worded to directly address this priority need.

Priority Need: Improve childhood nutrition

Pyramid Levels: Population based services, Enabling services

Population Groups: Children, Children with Special Health Care Needs

Capacity Specific to Need: Capacity exists to improve nutrition childhood nutrition through the Nutrition Unit in the Nutrition and WIC Section. While the nutrition unit has focused on the WIC population, this focus can be expanded to provide increased population-based messaging. MCH Program staff have contributed to discussion pertaining to farm-to-school initiatives and initial plans have been made to develop an RFP to fund increased nutrition education in schools that also develop school-based gardens. To ensure inclusion for children with special health care needs, Nutrition Unit staff have provided training and nutritionists have been hired to support Georgia's Part C Early Intervention Program -- Babies Can't Wait.

Related NPMs and SPMs: SPM 1

Relationships between NPMs, SPMs, and Priority Needs: While SPM 1 directly addresses obesity, improvements in childhood nutrition will contribute to reductions in obesity. This priority need will be addressed by ensuring that activities to improve childhood nutrition are included in the SPM 1 activity plan.

Priority Need: Increase awareness of the need for preconception health care among women of childbearing age

Pyramid Levels: Population based services, Enabling services, Direct health care

Population Groups: Women and infants

Capacity Specific to Need: There are several opportunities for the dissemination of preconception health messaging through MCH programs. The Family Planning Program in the Women's Health Unit has opportunities to develop standard messages that can be delivered through client contacts. Through improved collaboration with Medicaid and the implementation of Georgia's Women's Health Waiver, there will be opportunities to increase population-based media messages pertaining to family planning and preconception health. Through coordination with WIC, women who have given birth can receive interconception health messages to increase the likelihood of healthy future pregnancies. The MCH Program will need to work with the Health Promotion and Disease Prevention Program and internal experts in communications to develop strategies to ensure broad dissemination of preconception health messages.

Related NPMs and SPMs: NPMs 15, 18 and SPM 8

Relationships between NPMs, SPMs, and Priority Needs: Several state and national performance measures can contribute to achieving success for this priority need. SPM 8 addresses folic acid consumption prior to conception. NPM 15 addresses cigarette smoking in the third trimester of pregnancy. By incorporating anti-smoking messages among child bearing age, NPM 15 can contribute to improvement in this priority need. NPM 18 addresses early entry into prenatal care. Early entry into prenatal care requires awareness and planning of pregnancy. Improved preconception messages to support NPM 18 will also positively impact this priority need.

Priority Need: Increase the percent of qualified medical providers who accept Medicaid and who serve children with special health care needs

Pyramid Levels: Infrastructure building

Population Groups: Children with special health care needs

Capacity Specific to Need: Current contracts with the Georgia Chapter of the American Academy of Pediatrics and the Georgia Association of Family Physicians provide access to practicing providers. With the assistance of these partners, surveys will be implemented to determine the current attitudes of practicing providers to treating children with special health care needs. MCH Program staff will work to develop recognition programs for providers who have positive attitudes

toward treating CSHCN and who ensure family involvement in decision making.

Related NPMs and SPMs: SPM 6

Relationships between NPMs, SPMs, and Priority Needs: SPM 6 monitors the percent of pediatricians and family physicians with positive attitudes toward treating CSHCN. Provider willingness to care for CSHCN is central to ensuring adequate supply. Through activity plans associated with SPM 6, it is hypothesized that the percent of providers with positive attitudes can be increased, which may impact the supply of qualified providers serving CSHCN. Activities will equally focusing on the existing provider community and students still matriculating in medical schools throughout Georgia.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	216	256	210	210	327
Denominator	216	256	210	210	327
Data Source				Georgia NBS Program	Newborn Screening Program
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	2011	2012	2013	2014
Annual Performance Objective	100	100	100	100	100

Notes - 2009

As per Form 6, the data reported here are lagged by one year. Therefore, the data reported in the 2009 column are data collected in 2008.

a. Last Year's Accomplishments

Contracted with the Medical College of Georgia (MCG) and Grady Sickle Cell Disease Centers to follow up abnormal hemoglobin results.

Contracted with Emory Genetics to follow up on remaining Newborn Screening disorders.

Modified SENDSS Newborn to include hospital performance reports that monitor collection and transport quality. Participating hospitals are now able to view their performance data as needed.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitoring referrals of infants diagnosed with metabolic and hemoglobinopathies to appropriate CSHCN programs.			X	
2. Including funds for special formulas in Metabolic Follow Up contract.		X		
3. Providing specialized formulas, as needed.				X
4. Collaborating with Newborn Screening program regarding policies, procedures and development of SENDSS Newborn.				X
5. Continuing MCH Epidemiology linkage of newborn screening records with Electronic Birth Certificates.			X	
6. Providing access to and monitor hospital reports to identify each hospital's unsatisfactory specimens.				X
7. Following up on all abnormal screening test results contractually.				X
8. Holding regular Advisory Committee and work group meetings to address and resolve issues within the NBS system.				X
9. Providing NBS education to parents and providers.		X		
10.				

b. Current Activities

Filled vacant Director of Chemistry and Hematology (includes Newborn Screening) position in the Georgia Public Health Laboratory.

Resumed Newborn Screening Advisory Committee Operations Work Group and Endocrine Work Group meetings.

Identified one year and five year priorities to address identified gaps in the Newborn Screening (NBS) system.

Updated the NBS web site.

Hired temporary staff to manually match birth records to screening tests that were not auto-matched in SendSS.

Began monthly reviews of open abnormal hemoglobin cases to discuss barriers to timely diagnosis and treatment.

Implemented United Parcel Service (UPS) delivery of confirmatory samples from the hemoglobin follow-up coordinator at Grady and the Sickle Cell Foundation to the Hemoglobin Lab at the Medical College of Georgia.

c. Plan for the Coming Year

Activity 1. Reduce the number of unsatisfactory specimens (unsats) by identifying hospitals who submit unsats; notifying those providers of their specimen collection performance; and conducting site visits and offering technical assistance and training to improve specimen collection techniques.

Output(s). Percent of hospitals with unsat rates less than or equal to 1%; percent of unsatisfactory newborn screens; documentation of site visits, technical assistance and training

activities.

Monitoring. Monthly review of site visits, technical assistance and training activities; percent increase/decrease in unsats, and percent increase/decrease of hospitals with unsats less than or equal to 1%.

Activity 2. Implement a protocol that identifies and tracks newborn screens from unsatisfactory to satisfactory.

Output(s). Percent of newborns that receive an unsat screen who have a repeated screen; percent of newborns that receive a repeated satisfactory screen; and a protocol that identifies and tracks newborn screens from unsatisfactory to satisfactory.

Monitoring. Monthly review of newborns that receive repeated screens and repeated satisfactory screens.

Activity 3. Educate pre- and postnatal families and healthcare professionals about newborn screening (NBS) and the importance of follow-up for positive results by disseminating information via multiple communication methods, including PSAs, the NBS brochure and web site, social networking sites, newsletter articles, and training/professional development.

Output(s). Type and number of materials distributed; number of newsletter articles written; number of presentations given; number of friends and networks on social networking sites.

Monitoring. Quarterly review of education activities. Bi-monthly monitoring and updates of social networking sites.

Activity 4. Improve the electronic database (SendSS) and monitoring capabilities by developing an unsatisfactory specimen tracking module, creating metabolic reports and improving matching algorithms.

Output(s). Percent of newborn screens matched to the birth record; metabolic reports developed; completed module for unsatisfactory specimen tracking; protocol for the follow-up of unmatched birth certificates and newborn screens.

Monitoring. Notes from meetings to review the progress towards the completion of the module, the reports, and matching algorithm; meeting attendance.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	144459			
Reporting Year:	2008			
Type of Screening Tests:	(A) Receiving at least one Screen (1)	(B) No. of Presumptive Positive Screens	(C) No. Confirmed Cases (2)	(D) Needing Treatment that Received Treatment

					(3)	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	128182	88.7	90	6	6	100.0
Congenital Hypothyroidism (Classical)	128182	88.7	5024	82	82	100.0
Galactosemia (Classical)	128182	88.7	1689	2	2	100.0
Sickle Cell Disease	128182	88.7	194	153	153	100.0
Biotinidase Deficiency	128182	88.7	49	2	2	100.0
Cystic Fibrosis	128182	88.7	3463	45	45	100.0
Homocystinuria	128182	88.7	150	1	1	100.0
Maple Syrup Urine Disease	128182	88.7	21	0	0	
beta-ketothiolase deficiency	128182	88.7	44	0	0	
Tyrosinemia Type I	128182	88.7	77	0	0	
Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	128182	88.7	109	2	2	100.0
Argininosuccinic Acidemia	128182	88.7	50	2	2	100.0
Citrullinemia	128182	88.7	50	0	0	
Isovaleric Acidemia	128182	88.7	28	0	0	
Propionic Acidemia	128182	88.7	21	0	0	
Carnitine Uptake Defect	128182	88.7	159	0	0	
3-Methylcrotonyl-CoA Carboxylase Deficiency	128182	88.7	44	7	7	100.0
Methylmalonic acidemia (Cbl A,B)	128182	88.7	109	2	2	100.0
Multiple Carboxylase Deficiency	128182	88.7	44	0	0	
Glutaric Acidemia Type I	128182	88.7	84	2	2	100.0
21-Hydroxylase Deficient Congenital Adrenal Hyperplasia	128182	88.7	1334	10	10	100.0
Medium-Chain Acyl-CoA Dehydrogenase	128182	88.7	43	11	11	100.0

Deficiency						
Long-Chain L-3-Hydroxy Acyl-CoA Dehydrogenase Deficiency	128182	88.7	27	1	1	100.0
3-Hydroxy 3-Methyl Glutaric Aciduria	128182	88.7	21	1	1	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures

[Secs 485 (2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	60.8	60.8	60.8	55	56
Annual Indicator	60.8	60.8	54.0	54.0	54.0
Numerator			188652	190386	193268
Denominator			349356	352567	357903
Data Source				NS-CSHCN	NS-CSHCN
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	2011	2012	2013	2014
Annual Performance Objective	55.1	56.2	57.3	58.5	60

Notes - 2009

Data used to populate this measure were from the 2005/2006 National Survey of Children with Special Health Care Needs. The annual indicator will reflect the data from this survey until a new data source or an updated survey is available.

Numerator and denominator estimates were made. These estimates are important to demonstrate that while the percent remains constant the number of affected children increased as the population grows. Numerator data were estimated by multiplying the percent by the denominator. The denominator is estimated by multiplying the CSHCN prevalence (13.9%) by the total number of children ages birth to 17 years. The total number of children ages birth to 17 years is from population projections provided by OASIS. Population projections were not available for 2009. The population estimate for 2009 was estimated using a linear projection with data from 2000 through 2008.

Sufficient data are not available to use a projection to forecast the annual performance objective between 2010 through 2014. An anticipated 2% increase will be applied to the annual performance objective in 2009.

Notes - 2008

Data is from the 2005-2006 SLAITS survey. Data for CY 2008 will not be available until the 2007-2008 survey is conducted and results are posted.

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments

Involved families in the development of client plans of care (POC). Families were encouraged to determine the priority for the child and his/her needs.

At the health district level, supported Babies Can't Wait (BCW) and Children's Medical Services (CMS) local councils and their parent members.

Supported clients and their families in attending diabetes and asthma camps. Some districts conducted asthma camps on site.

At the health district level, participated in Family Connection initiatives and Head Start programs.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continuing family participation through development of CMS care coordination plan of care.		X		
2. Conducting CMS family satisfaction survey statewide every three years as well as an ongoing survey as part of CMS quality assurance programmatic/fiscal review (three year cycle).				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Initiated a Family Action and Support Team in 18 health district CMS offices to foster family involvement in decision-making regarding the care of their child.

Through CMS coordinators in the 18 health districts, provided asthma education to children with asthma and their families. CMS coordinators provide school nurses with education on avoidance of asthma triggers and use of a child's asthma action plan.

Provided funding at the district for asthma camp tuition support. Some districts sponsored local asthma camps.

Through the Georgia Asthma Control Program (GACP), provided funding to support asthma education efforts in seven health districts and partnered with to promote the adoption of "Asthma Friendly School" policies. GACP partnered with the Georgia Association of School Nurses (GASN) to provide asthma education and awareness to students, school staff, and parents.

Funded GASN to purchase nebulizers, pulse oximeters, spacers, and peak flow meters to better serve the children that school nurses encounter.

Formed a GASN Asthma Task Force to provide support in making all Georgia schools asthma friendly.

Through GACP, partnered with Children's Healthcare of Atlanta (CHOA) to work with families, schools, and health providers to assure children with asthma achieve their health and learning potential.

With funding from the Centers for Disease Control and Prevention (CDC), collected asthma surveillance data and published a GACP report on the burden of asthma in Georgia.

c. Plan for the Coming Year

Activity 1. Involve families of CSHCN receiving services from CMS in the development of plans of care.

Output(s). % of families with input on plans of care; # of families that determined the priority for the child and his/her need.

Monitoring. Quarterly reports.

Activity 2. Plan for the development of an online family leadership training module.

Output(s). Work plan; contract to develop content and technical aspects of the training module.

Monitoring. Quarterly reports.

Activity 3. Provide funding for families to attend local BCW council meetings.

Output(s). # of families funded to attend; % increase in the # attending.

Monitoring. Quarterly reports.

Activity 4. Provide funding for CSHCN and their families to attend diabetes, metabolic, genetics, and asthma camps.

Output(s). # of families/children funded to attend camps.

Monitoring. Quarterly reports.

Activity 5. Host a planning meeting with state agencies, youth with juvenile diabetes, family representatives, and advocates concerned about juvenile diabetes to develop a partnership and work plan.

Output(s). Work plan.

Monitoring. # of meetings; meeting attendance; meeting minutes.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
---------------------------------------	------	------	------	------	------

Annual Performance Objective	50	50	51	51	51
Annual Indicator	49.4	49.4	51.0	51.0	51.0
Numerator			178172	179809	182531
Denominator			349356	352567	357903
Data Source				NS- CSHCN	NS- CSHCN
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	2011	2012	2013	2014
Annual Performance Objective	52	53.1	54.1	55.2	56.3

Notes - 2009

Data used to populate this measure were from the 2005/2006 National Survey of Children with Special Health Care Needs. The annual indicator will reflect the data from this survey until a new data source or an updated survey is available.

Numerator and denominator estimates were made. These estimates are important to demonstrate that while the percent remains constant the number of affected children increased as the population grows. Numerator data were estimated by multiplying the percent by the denominator. The denominator is estimated by multiplying the CSHCN prevalence (13.9%) by the total number of children ages birth to 17 years. The total number of children ages birth to 17 years is from population projections provided by OASIS. Population projections were not available for 2009. The population estimate for 2009 was estimated using a linear projection with data from 2000 through 2008.

Sufficient data are not available to use a projection to forecast the annual performance objective between 2010 through 2014. An anticipated 2% increase will be applied to the annual performance objective in 2009.

Notes - 2008

Data is from the 2005-2006 SLAITS survey. Data for CY 2008 will not be available until the 2007-2008 survey is conducted and results are posted.

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

a. Last Year's Accomplishments

On admission to CMS program and annually, assessed whether or not a child had a medical home.

Assessed children referred to the BCW program for presence of a primary care provider (PCP). BCW program service coordinators regularly reviewed medical home information and presence of a medical home was included as part of the individual family service plan.

Referred clients without a primary care provider (PCP) to a provider. Ninety-six percent of CMS clients had a PCP.

Co-led Georgia Early Child Comprehensive System (ECCS) workgroup on access to medical and dental home.

Populated web-based ECCS clearinghouse with information and web links on the importance of medical and dental homes for children.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continuing CYSN participation in MCH Early Childhood Comprehensive Systems (ECCS) grant. (One component of the grant is the planning and implementation of infrastructure for statewide Medical Home Initiative for all children.)				X
2. Continuing to facilitate CYSN program enrollees accessing medical home.		X		
3. Documenting the percentage of CYSN enrollees who have documented medical home.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

On admission to CMS program and annually, assessed whether or not a child had a medical home.

Connected children and families referred to BCW with a primary care provider, if needed. BCW program service coordinators regularly review medical home information and include the information as part of the individual family service plan.

Referred CMS clients without a PCP to a provider on admission to the program. In the second quarter of FY 2010, 94% of CMS clients had a PCP.

c. Plan for the Coming Year

Activity 1. Provide professional development to state and district level staff, families, and medical and non-medical providers on the definition and components of a medical home.

Output(s). # of trainings; # of staff trained; positive change in baseline knowledge; # of medical/dental home brochures distributed.

Monitoring. Training registration; training schedule and plan.

Activity 2. Assess new BCW and CMS clients for a primary care provider and make appropriate referrals for clients without a medical home.

Output(s). # of clients who have been assessed for a primary care provider; # of referrals made to clients who did not have a primary care provider; % of clients who have an identified primary care

provider.

Monitoring. Quarterly reports.

Activity 3. Meet with leadership from the Georgia Chapter of AAP and AFP to develop a strategy to increase the availability of medical homes throughout Georgia.

Output(s). Strategic plan.

Monitoring. Meeting minutes; meeting attendance roster.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	57	57	58	62	62
Annual Indicator	56.4	56.4	61.2	61.2	61.2
Numerator			213806	215771	219037
Denominator			349356	352567	357903
Data Source				NS- CSHCN	NS- CSHCN
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	2011	2012	2013	2014
Annual Performance Objective	62.4	63.7	64.9	66.2	67.5

Notes - 2009

Data used to populate this measure were from the 2005/2006 National Survey of Children with Special Health Care Needs. The annual indicator will reflect the data from this survey until a new data source or an updated survey is available.

Numerator and denominator estimates were made. These estimates are important to demonstrate that while the percent remains constant the number of affected children increased as the population grows. Numerator data were estimated by multiplying the percent by the denominator. The denominator is estimated by multiplying the CSHCN prevalence (13.9%) by the total number of children ages birth to 17 years. The total number of children ages birth to 17 years is from population projections provided by OASIS. Population projections were not available for 2009. The population estimate for 2009 was estimated using a linear projection with data from 2000 through 2008.

Sufficient data are not available to use a projection to forecast the annual performance objective between 2010 through 2014. An anticipated 2% increase will be applied to the annual performance objective in 2009.

Notes - 2008

Data is from the 2005-2006 SLAITS survey. Data for CY 2008 will not be available until the 2007-2008 survey is conducted and results are posted.

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments

Assessed the level of health care covered by insurance or Medicaid for all clients entering the CMS arena.

Based on eligibility, assisted CMS clients with insurance applications. Approximately 64% of CMS clients had Medicaid, 6.5% were enrolled in PeachCare for Kids, 12% had private insurance, 1% had TriCare, and 16% only had CMS.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitoring payment sources for services (i.e., types of insurance) and refer families to potential resources.				X
2. Developing a plan to identify service needs of families not covered by insurance.				X
3. Continuing to work with Medicaid and PeachCare to link all eligible children.		X		
4. Collaborating with the Governor's Office of Highway Safety on a middle childhood initiative to provide primary education to children under age 14 on motor vehicle safety.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Determined the level of health care coverage (i.e., insurance, Medicaid, PeachCare for Kids) for all clients entering the CMS program.

Based on eligibility, assisted CMS clients with insurance applications. Of the 8,793 CMS clients enrolled in the second quarter of FY 2010, approximately 67% had Medicaid, 6% were enrolled in PeachCare for Kids, 12% had private insurance, 1% had TriCare, and 14% had CMS only.

c. Plan for the Coming Year

Performance Measure 04: The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need.

Activity 1. Assess insurance status and coverage of new clients in CMS and BCW.

Output(s). Annual report of insurance coverage in CMS and BCW; percent of new clients assessed; percent with insurance coverage by type of coverage.

Monitoring. Quarterly reports.

Activity 2. Assist CMS and BCW clients apply for Medicaid and other insurance benefits.

Output(s). # of clients who applied for insurance as a result of assistance; # of clients who applied who received additional benefits.

Monitoring. Quarterly reports.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	75	75	76	92	92
Annual Indicator	74.9	74.9	91.0	91.0	91.0
Numerator			317914	320836	325692
Denominator			349356	352567	357903
Data Source				NS- CSHCN	NS- CSHCN
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	2011	2012	2013	2014
Annual Performance Objective	92.8	94.7	96.6	98.5	100

Notes - 2009

Data used to populate this measure were from the 2005/2006 National Survey of Children with Special Health Care Needs. The annual indicator will reflect the data from this survey until a new data source or an updated survey is available.

Numerator and denominator estimates were made. These estimates are important to demonstrate that while the percent remains constant the number of affected children increased as the population grows. Numerator data were estimated by multiplying the percent by the denominator. The denominator is estimated by multiplying the CSHCN prevalence (13.9%) by the total number of children ages birth to 17 years. The total number of children ages birth to 17 years is from population projections provided by OASIS. Population projections were not available for 2009. The population estimate for 2009 was estimated using a linear projection with data from 2000 through 2008.

Sufficient data are not available to use a projection to forecast the annual performance objective between 2010 through 2014. An anticipated 2% increase will be applied to the annual performance objective in 2009.

Notes - 2008

Data is from the 2005-2006 SLAITS survey. Data for CY 2008 will not be available until the 2007-2008 survey is conducted and results are posted.

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

a. Last Year's Accomplishments

Updated CMS brochure and translated it into Spanish.

Updated the CMS web site.

In rural areas of the state, conducted CSHCN specialty clinics to enhance access in communities lacking specialty services.

Using telemedicine, provided community-based services for CSHCN in one rural health district.

Worked with the BCW and Infant and Child Health (ICH) program coordinators to assess training, technical assistance, and resource sharing needs to facilitate collaboration across programs.

Completed CMS statewide survey. Eighty-three percent (84%) of families participating in the survey indicated they "strongly agreed/agreed that the community-based services are organized so that they can access them easily."

Held stakeholder meetings to obtain input on CMS restructuring. Families participated in the stakeholder meetings.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Gathering data from other states and MCHB sponsored contracts that have completed previous work in this area.				X
2. Conducting CMS family satisfaction survey statewide every three years as well as an ongoing survey as part of CMS quality assurance programmatic/fiscal review (three year cycle).				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Held CMS specialty physical education staff clinics to provide medical care for children with special health care needs living in underserved areas. In FY 2009, over 8,700 CMS enrollees and approximately 7,000 children aged birth to 21 who were not enrolled in CMS received specialty physician services in CMS staffed clinics.

Through specialty physician clinics, provided care coordination and medical management

services to children and families who would have otherwise had to travel long distances to see a physician.

c. Plan for the Coming Year

Activity 1. Assist families served in CMS and BCW with accessing available community resources.

Output(s). # of referrals made; # of website hits to resource guide website' # of families receiving assistance.

Monitoring. Quarterly reports.

Activity 2. Conduct specialty clinics for CSHCN in areas with limited specialty providers/services.

Output(s). # of clients; # of clinics conducted.

Monitoring. Quarterly reports.

Activity 3. Encourage expansion of telemedicine use in health districts.

Output(s). # of health districts implementing telemedicine that are in need of expanding services.

Monitoring. Quarterly reports.

Activity 4. Conduct a survey of CMS client families to measure understanding of the availability of community-based services and barriers to accessing these services.

Output(s). Report of survey results.

Monitoring. Quarterly reports on progress; drafts of survey instrument.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	6	6	6	38	38
Annual Indicator	5.8	5.8	37.0	37.0	37.0
Numerator			129262	130450	132424
Denominator			349356	352567	357903
Data Source				NS- CSHCN	NS- CSHCN
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final

	2010	2011	2012	2013	2014
Annual Performance Objective	37.7	38.5	39.3	40	40.9

Notes - 2009

Data used to populate this measure were from the 2005/2006 National Survey of Children with Special Health Care Needs. The annual indicator will reflect the data from this survey until a new data source or an updated survey is available.

Numerator and denominator estimates were made. These estimates are important to demonstrate that while the percent remains constant the number of affected children increased as the population grows. Numerator data were estimated by multiplying the percent by the denominator. The denominator is estimated by multiplying the CSHCN prevalence (13.9%) by the total number of children ages birth to 17 years. The total number of children ages birth to 17 years is from population projections provided by OASIS. Population projections were not available for 2009. The population estimate for 2009 was estimated using a linear projection with data from 2000 through 2008.

Sufficient data are not available to use a projection to forecast the annual performance objective between 2010 through 2014. An anticipated 2% increase will be applied to the annual performance objective in 2009.

Notes - 2008

Data is from the 2005-2006 SLAITS survey. Data for CY 2008 will not be available until the 2007-2008 survey is conducted and results are posted.

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

a. Last Year's Accomplishments

Continued to develop transition plans for CMS clients aged 16 to 21; 96% of CMS clients in this age range had a transition plan.

Monitored district transition planning data quarterly.

Provide technical assistance to support district use of CMS Transition Manual in developing transition plans for children with special needs ages 16 to 21.

Administered statewide survey of district CMS professional staff to determine training needs.

Participated in Healthy and Ready to Work (HRTW) topical calls on transitioning of CSHCN.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continuing to provide literature and updates on transition services to district coordinators.		X		
2. Planning to produce packet of transition materials for district coordinators to use with clients and families.				X

3. Collecting data on percent of clients and families with a transitional plan of care.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Developed transition plans for CMS clients ages 16 to 21. Of the 1,390 CMS clients in the 16 to 21 age group, 95% had a transition plan in FY 2009.

Monitored district transitional planning quarterly.

Supported health district use of the CMS Transition Manual with CMS clients ages 16 to 21.

Planning additional staff training on the use of the CMS Transition Manual.

Continued to participate in Healthy and Ready to Work (HRTW) CSHCN topical calls.

c. Plan for the Coming Year

Activity 1. Develop transition plans for CMS clients ages 16 to 21 years.

Output(s). % of CMS clients who have a documented transition plan.

Monitoring. Quarterly reports from CMS staff.

Activity 2. Update CMS Transition Manual and provide training to district staff on use of CMS Transition Manual.

Output(s). Updated manual; number of trainings conducted; number of staff trained.

Monitoring. Quarterly reports on progress of manual update; statewide training plan; invitations distributed for training; quarterly reports on registration status.

Activity 3. Schedule meeting with Family Voices, Department of Education, Department of Labor/Rehabilitation Services, Department of Juvenile Justice, Division of Family and Children Services, Governor's Council on Developmental Disabilities, and other relevant agencies to develop strategies to improve transition.

Output(s). Work plan; policy statement.

Monitoring. Meeting minutes; meeting attendance roster.

Activity 4. Conduct a survey of CMS client families and providers to measure understanding of transition planning and transitioning.

Output(s). Report of survey results.

Monitoring. Quarterly reports on progress; drafts of survey instrument.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	85	85	85	85	85
Annual Indicator	82.4	82.4	76.0	71.9	76.7
Numerator			157809	149988	164964
Denominator			207643	208606	215153
Data Source				NIS	NIS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	77	77.5	78	78.5	79

Notes - 2009

Data reflect the 4:3:1:3:3:1 immunization series. Data retrieved from <http://www.cdc.gov/vaccines/stats-surv/imz-coverage.htm#nis> on May 13, 2010. Numerator and denominator are estimates based on the percentage reported by the National Immunization Survey. Data are unavailable for 2009. The 2009 estimate is developed using a linear projection with data from 2000 through 2008. The number of children 19 to 35 months is estimated by taking the number of children age 1 year dividing by 12 and multiplying by 5 plus all children age 2 years. Population estimates are provided by the Georgia Online Analytical Statistical Information System.

To ensure data integrity across previous years, data were updated for 2007, 2008, and 2009.

The average annual percent change for this indicator is approximately zero (-0.02%). The annual performance objective estimates reflect Georgia's goal of building on the projected increase in FY09 and making progress toward achieving rates previously reported in 2006.

a. Last Year's Accomplishments

Increased computer interfaces available for providers to download immunization data directly into GRITS, enhancing the availability of vaccine records.

Enrolled additional childcare organizations in GRITS.

Assessed private provider immunization records using CoCASA software to increase vaccination levels by measuring rates against national standards.

To increase awareness of national recommendations and state requirements for immunizations, provided education to provider groups through exhibits and conferences.

Ensured local health department staff worked with WIC clinics to assess client immunization records and refer clients, as needed, for follow up care with health care provider.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participating in quarterly immunization coordinators meetings.				X
2. Promoting childhood immunizations during all activities that target young children, i.e., Children 1st, Healthy Childcare Georgia, Health Check, etc.			X	
3. Including immunization assessment during desk audits and in programs, e.g., WIC.	X			
4. Collaborating with DCH and GA-AAP to assure that private providers offer appropriate services, including immunizations and developmental screenings to children who are enrolled.				X
5. Monitoring health status of at-risk children birth to age 5 through Children 1st.			X	
6. Assessing immunization information at childcare facilities to ensure children are protected against vaccine preventable disease.			X	
7.				
8.				
9.				
10.				

b. Current Activities

Increased computer interfaced available for providers to download immunization data directly into GRITS, enhancing the availability of vaccine records.

Enrolled additional childcare organizations in GRITS to view immunization records and refer non-compliant children to health care providers for needed vaccines.

Assessed private provider immunization records using CoCASA software to increase vaccination levels by measuring rates against national standards.

Provided education to provider groups through exhibits and conferences to increase their understanding of the national recommendations and state requirements for immunizations.

Ensured that local health department staff are working with WIC clinics to assess client immunization records and refer them to follow up care with health care provider.

c. Plan for the Coming Year

Activity 1. Develop a strategic plan and pilot project to improve the immunization rates in WIC clinics.

Output(s). Strategic plan; description of pilot project; selected pilot project locations.

Monitoring. Planning meetings; attendance sheets.

Activity 2. Improve coordination with Children's Medical Services and Babies Can't Wait to increase immunization rates among children with special health care needs.

Output(s). Percent of Children's Medical Services and Babies Can't Wait clients who are appropriately and adequately immunized.

Monitoring. Quarterly reports.

Activity 3. Increase Hepatitis B birth dose rates and follow-up with Hepatitis B positive mothers.

Output(s). # of data sets queried to find mothers who are Hepatitis B positive; # of women contacted; # of presentations at hospitals to improve data recording; # of hospitals adopting model policies.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	29	29	28	28	27
Annual Indicator	28.0	28.0	29.4	28.3	27.1
Numerator	5260	5260	5756	5610	5489
Denominator	187616	187616	195685	198043	202866
Data Source				Vital Records	Vital Records
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	26.3	25.5	24.7	24	23.2

Notes - 2009

Birth record data are unavailable for 2008 and 2009. The provisional estimates are developed using a linear projection with data from 2000 through 2007. Population data provided by the Georgia Online Analytic Statistical Information System. Population data for 2009 are estimated using a linear projection with data from 2000 through 2008.

Data were updated for 2007, 2008, and 2009.

Annual performance objective estimates are developed by applying the average annual percent change (-3.0%) between 2000 through 2009 to the 2009 point estimate.

a. Last Year's Accomplishments

Served 15,824 unduplicated teens between the ages of 15 and 17 in the Georgia Family Planning Program. An additional 19,009 teens between the ages of 18 and 19 were served as well. The range of services provided included physical assessment, immunizations, skilled counseling and age appropriate information (i.e., nutrition, exercise, smoking cessation, substance use and abuse, domestic violence, sexual coercion, sexual concerns, and mental health concerns), contraceptive services including abstinence, and education on safer sex practices to reduce risk for STD/HIV and pregnancy. While services are confidential, family participation in an

adolescent's decisions regarding family planning was encouraged.

Funded 30 teen center programs in 27 counties, a Youth Development Coordinator in each of the 18 public health districts, and 7 Sexual Violence Prevention (RPE) programs located throughout Georgia. Teen center programs are operated through county health departments statewide and located in counties reporting high rates of high school dropouts, HIV/STDs, and/or teen pregnancy. Each program has established a Parent Advisory Committee to provide parents a meaningful way to participate in planning, decision-making, and opportunities for positive health promotion in each of the targeted communities. The RPE programs provide education, training, materials, information hotlines, and other prevention activities for school age youth and young adults. Also provided professional development and training for law enforcement, health care, and social service providers on methods of preventing sexual violence.

Implemented 29,946 comprehensive health and youth development service plans, 4,355 youth-focused activities/events, 545 public awareness and community education events, 332 professional in-service training events, and 2,661 RPE educational sessions for 68,696 participants. Distributed 86,936 RPE informational units.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continuing training, technical assistance and monitoring of contracts and Grant-in-Aid (GIA), both of which include deliverables that address community and parent education/collaboration, outreach, and youth development activities for teens.				X
2. Collaborating with DCH to provide linkage with Medicaid and PeachCare for Kids for case management and receipt of medical services.				X
3. Collaborating with the Department of Juvenile Justice to provide services to youth. Collaborating with DCH to provide linkage with Medicaid and PeachCare for Kids for case management and receipt of medical services upon release.				
4. Operating family planning clinics for teens in health department and non-traditional sites (e.g., night clinic, vans, jails, DFCS offices).	X			
5. Funding Southside Medical Hospital Project, working with adolescent males to encourage them to get involved in health care.		X		
6. Providing abstinence and teen pregnancy information and contraceptive services in teen centers operating in each district.			X	
7. Participating in the development of Regional Comprehensive Youth Development Systems throughout Georgia.				X
8.				
9.				
10.				

b. Current Activities

Served 13,403 unduplicated teens between the ages of 15 and 17 in SFY 2009. An additional 15,987 teens ages 18 and 19 were also served. Services provided include, but are not limited to, physical assessment, immunizations, skilled counseling and age appropriate information (i.e., smoking cessation, sexual coercion, and sexual concerns), contraceptive services including abstinence, and education on safer sex practices to reduce the risk for STD/HIV and pregnancy.

While services are confidential, parental participation in an adolescent's decisions regarding family planning is encouraged.

Included teen pregnancy prevention activities in district Title X Family Planning work plans. Examples of successful district adolescent pregnancy activities include a marketing campaign ("Promoting Awareness of Teen Health and Sexuality -- PATHS) implemented in the Coastal Health District to encourage teens to make responsible choices and a community action plan developed and implemented in the Northeast Health District based on district Behavior and Risk in Teens (BART) survey data.

c. Plan for the Coming Year

Activity 1. Increase opportunities to engage in teen pregnancy prevention activities at the state and local levels.

Output(s). The number of teens (17 years of age and younger) receiving services through the Teen Center programs; the number of Teen Center programs implementing an evidence-based program/curriculum; the number of teens receiving services through Title X family planning clinics; number of adolescents receiving WIC services who receive referrals to family planning.

Monitoring. Review quarterly and annual reports submitted by Teen Center programs, Title X, and WIC.

Activity 2. Partner with external and internal stakeholders and a selected university partner to increase surveillance capacity identify gaps in teen pregnancy prevention knowledge and develop and implement a plan to resolve these gaps.

Output(s). Research proposal; contract to fund research proposal; institution review board approval.

Monitoring. Number of meetings, meeting minutes.

Activity 3. Develop a report on the state of teen pregnancy and repeat teen pregnancy in Georgia.

Output(s). Development of report, number of reports distributed; number of attendees at release of teen pregnancy and repeat teen pregnancy report; number of times the report was downloaded from Internet site.

Monitoring. Quarterly reports on progress of report and scheduling of events.

Activity 4. Convene multi-state agency workgroup to identify opportunities and develop a strategic plan for teen pregnancy activities.

Output(s). Division-approved strategic plan; work plan to implement teen pregnancy prevention activities.

Monitoring. Number of meetings; number of invitations issued to potential work group participants and number who accept; meeting minutes; meeting attendance.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	39	40	15	17.2	24
Annual Indicator	19.4	19.8	39.0	39.0	39.0
Numerator	9630	9188	48606	49478	50350
Denominator	49562	46506	124631	126867	129102
Data Source				Basic Screening Survey	Basic Screening Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	2011	2012	2013	2014
Annual Performance Objective	39.8	40	40.2	40.4	40.6

Notes - 2009

The percent of third grade children who have received a protective sealant on at least one permanent molar tooth is determined from the Basic Screening Survey. The Basic Screening Survey is a sample survey that includes an oral examination performed by a trained professional. The most recent Basic Screening Survey was for the 2005/2006 school year. This percent will be reported with updated numerator and denominator data based on the actual number of students enrolled in third grade. In the 2010/2011 school year, a new Basic Screening Survey is planned, which will provide updated data for this measure.

Denominator data from 2005-2006 K-12 Public Schools Annual Report Card (<http://reportcard2006.gaosa.org/k12/demographics.aspX?ID=ALL:ALL&TestKey=EnR&TestType=demographics>). All data reflect Fall enrollment except for 2006 which reflects Spring enrollment. Data for 2007, 2008, and 2009 are estimated with a linear projection methodology using data from 2003 through 2006.

Data were updated for 2007, 2008, and 2009.

As this indicator is populated using data from the 2005/2006 Basic Screening Survey until a new survey is completed, estimating the annual performance objective is difficult. Based on the data from the 2005/2006 survey (39% with sealants), a 0.5% increase would be expected annually from 2006 through 2014.

a. Last Year's Accomplishments

Received Centers for Disease Control and Prevention (CDC) State-Based Oral Disease Prevention Program grant. The five-year agreement provides funds to strengthen infrastructure and capacity to prevent oral disease and promote oral health, with a very strong emphasis on school-based/linked sealant programs. Oral Health hired a grant-funded Dental Sealant and Oral Health Education Specialist to plan, organize, and implement a comprehensive statewide school-based oral health education and dental sealant program.

Provided 6,929 children with dental sealants through the school-based and school-linked Oral Disease Prevention Program. In fixed clinic sites, 25,392 sealant procedures were performed.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continuing to visit schools to conduct screenings on children, place sealants when needed and provide prevention services, education, and fluoride treatments.			X	
2. Continuing implementation of statewide surveys that measure oral health status and the Access to Dental Services grant projects, including project monitoring and evaluation through submitted reports.			X	
3. Sharing Best Practices through quarterly Oral Health Coordinators' meetings with dental public health providers throughout the state.				X
4. Continuing to provide ongoing consultative support and technical assistance to the districts, including monitoring and evaluation.				X
5. Continuing provision of technical assistance and monitoring to district mobile dental trailer program to provide dental services at elementary school sites (selected by high student participation in the free and reduced lunch program).				X
6. Continuing efforts to build and strengthen infrastructure through school-based/linked program expansion (a statewide total of 12 trailers and 2 vans).				X
7. Continuing to train school and public health nurses on oral disease prevention and to provide oral screenings. Provision of training in application of fluoride varnish to the medical and dental professional communities.			X	
8. Through the Oral Health Coalition, assessing strategies to improve oral health and develop an Oral Health Plan.				X
9. Providing dental training to school nurses and WIC nutritionists.				X
10.				

b. Current Activities

Hired new Oral Health staff to strengthen program infrastructure and capacity.

Developed sealant, surveillance, and evaluation plans.

Developing a fluoridation plan.

Developing an oral health burden report.

Provided 4,850 children with dental sealants in FY 2009 through the school-based and school-linked Oral Health Disease Prevention Program. In fixed clinic sites, 18,672 sealant procedures were performed.

Planning survey to update data on third grade children who receive protective sealants on permanent molars.

c. Plan for the Coming Year

Activity 1. Increase the capacity to provide dental sealants through school-based programs.

Output(s). Number of sealant events occurring in school-based or community settings per year.

Monitoring. Quarterly review of data collected in CDC sealant-tracking system (SEALS).

Activity 2. Increase oral health surveillance capacity.

Output(s). # of questions asked about oral health in WIC; # of questions asked about oral health on PRAMS; # of questions asked about oral health on YRBS; # of questions asked about oral health on BRFSS; 3rd Grade Oral Health and Nutrition/Obesity Survey implemented in 2010/2011 school year.

Monitoring. Quarterly review of surveillance instruments and survey progress.

Activity 3. Promote the increased use of dental sealants to Public Health and community dental providers and educate them on evidence-based guidelines for the placement of sealants.

Output(s). Number of presentations given to Public Health and community dental providers; # of people trained.

Monitoring. Quarterly monitoring reports.

Activity 4. Provide education and training for dental and non-dental health care providers on initiation of infant oral health screening and fluoride varnish application by age one year.

Output(s). DCH/CMO policy that authorizes reimbursement for fluoride varnish application starting at age 6 months and requires training for non-dental providers; WIC-Oral Health pilot programs implemented in at least 2 county public health departments to provide oral health education and fluoride varnish to pregnant and new mothers, and fluoride varnish to their infant children; # of presentations to dental and non-dental providers on infant oral health care; # of dental and non-dental providers trained.

Monitoring. Yearly review of Medicaid data to determine percent of Medicaid-eligible children receiving at least one dental prevention service paid for by Medicaid program; development and implementation of a training plan and quarterly updates.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	4.2	4.2	3.4	4	3.5
Annual Indicator	3.5	3.5	3.6	3.4	3.2
Numerator	68	68	75	73	70
Denominator	1969278	1969278	2109362	2127815	2156790
Data Source				Vital Records	Vital Records
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5					

and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	3.2	3.1	3	2.9	2.8

Notes - 2009

Death record data are unavailable for 2008 and 2009. The number of deaths are developed using a linear projection with data from 2000 through 2007. Population data provided by the Georgia Online Analytic Statistical Information System. Population data for 2009 are estimated using a linear projection with data from 2000 through 2008.

Data were updated for 2007, 2008, and 2009.

Annual performance objective estimates are developed by applying the average annual percent change between 2000 through 2009 to the 2009 point estimate.

a. Last Year's Accomplishments

Provided child safety training, technical assistance, and monitoring activities.

Distributed child safety seats throughout Georgia to those in need.

Provided education to parents and other caregivers on child passenger safety and how to correctly install car seats.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Providing child passenger safety training, technical assistance and monitoring.	X			
2. Distributing child safety seats.		X		
3. Providing education on child passenger safety.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Through a grant from the Governor's Office for Highway Safety, provided child safety training, technical assistance, and monitoring activities.

Distributed car safety seats throughout Georgia to those in need.

Provided education to parents and other caregivers on child passenger safety and how to correctly install car seats.

c. Plan for the Coming Year

Activity 1. Distribute conventional seats and children with special health care needs-specific child safety seats.

Output(s). # of counties where seats were distributed; # of seats distributed.

Monitoring. Quarterly monitoring of the number of seats distributed to participating organizations and the number of safety seats distributed.

Activity 2. Document the number of children saved from serious injury or death due to program-funded child safety seats by applying Teddy Bear Stickers (TBS) to program-funded seats, encouraging participation in the TBS program, and processing TBS Fax Back Forms.

Output(s). Annual report of children saved.

Monitoring. Quarterly report on number of TBS Fax Back Forms received; develop and implement strategic plan for encouraging participation in TBS program.

Activity 3. Offer child passenger safety training to internal and external stakeholders.

Output(s). Types of training offered; # of trainings; # of people trained; # recertified; # of recertification trainings; # of Traffic Enforcement Network briefings conducted; # attending Traffic Enforcement Network briefings.

Activity 4. Host and participate in statewide Transporting Children with Special Health Care Needs conference.

Output(s). # of attendees; participant evaluation report; # of people trained to assess and respond to transportation challenges among children with special health care needs.

Monitoring. Review of notes from planning meetings.

Activity 5. Review of report on child deaths resulting from motor vehicle crashes and develop prevention policy recommendations and activities aimed at reducing such deaths.

Output(s). Annual Child Fatality Review Team Report on child deaths that includes motor vehicle crash deaths and policy recommendations.

Monitoring. Quarterly monitoring reports.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		31	32	33	35
Annual Indicator	30.4	29.2	30	39.1	40.5
Numerator				57539	60628
Denominator				147319	149765
Data Source				NIS	NIS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	42	43.5	45.1	46.7	48.2

Notes - 2009

The specific source for these data are http://www.cdc.gov/breastfeeding/data/nis_data accessed on May 14, 2010. Data are based on birth cohorts. As such, the measure of six month breastfeeding in the National Immunization Survey reports on activity in 2006 and 2007. Therefore, the data reported for the 2007 reporting year are from the 2006 birth cohort. Data from the 2007 and 2008 birth cohorts are not available. For the 2008 and 2009 reporting year, data were estimated using a linear projection with data from the 2000 through 2006 birth cohorts. While NIS is a sample survey, the numerator is estimated by multiplying the number of births reported for the specific birth cohort.

Data were updated for 2008 and 2009.

Annual performance objective estimates are developed by applying the average annual percent change (3.6%) between 2000 through 2009 to the 2009 point estimate.

Notes - 2007

This is survey data, a demoninator and numerator would not be feasible.

a. Last Year's Accomplishments

Implemented revised WIC data collection system to capture more accurate six-month breastfeeding duration rates.

Collaborated with Georgia Breastfeeding Coalition to implement "The Business Case for Breastfeeding," a federally created program that trains lactation specialists, including peer counselors, to provide outreach and technical assistance to small and large businesses interested in establishing a lactation support program for employees. Training continued across the state under the guidance of the original grant recipients.

Maintained lactation room at the Department of Community Health (DCH) state office building for use by mothers and visitors.

Revised peer counselor program guidelines and created site visit review tool.

Provided 37 peer counselors in seven peer counselor programs across the state with customized training by an experienced contractor.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintaining breastfeeding coalitions and collaborative efforts at the state and district level.			X	
2. Assisting districts in implementing breastfeeding education and support plans.				X
3. Continuing monitoring and surveillance of breastfeeding initiation and duration data.		X		
4. Integrating breastfeeding promotion into relevant MCH, public				X

health and community-based programs to prevent obesity.				
5. Continuing to implement revised data collection system in WIC Branch and monitoring new data on duration rates.		X		
6. Distributing revised Peer Counselor Program Guidelines to district programs as standards of care and best practices.				X
7. Making site visits to district Peer Counselor Programs to offer technical assistance and conduct program evaluations.				X
8. Expanding outreach to Georgia businesses and corporations via "The Business Cases for Breastfeeding" toolkit.				X
9. Maintaining the Lactation Room at the state office building.		X		
10. Continuing contract for Peer Counselor training and Peer Counselor supervisor in-service training and education.				X

b. Current Activities

Collaborated with Healthy Start programs across the state and with the State Perinatal Program manager to improve breastfeeding duration rates and maternity care practices that support breastfeeding.

Revised the WIC data collection system to accurately capture six month breastfeeding duration rates.

Collaborated with DPH epidemiology and information technology (IT) staff to create a web-based peer counselor program data collection system.

Instituted a breastfeeding team at the State Office which meets monthly to plan and implement breastfeeding promotion and support activities across program lines.

Initiated planning for a Baby Café project (community-based walk-in center for mother to mother breastfeeding support).

c. Plan for the Coming Year

Activity 1. Increase surveillance of breastfeeding rates and community attitudes to breastfeeding.

Output(s). Development of a biennial survey to be implemented in WIC clinics; add questions to state BRFSS; add questions to state YRBSS.

Monitoring. Quarterly reports.

Activity 2. Standardize and improve breastfeeding messaging statewide.

Output(s). Development and implementation of a statewide media campaign to promote breastfeeding.

Monitoring. Contract with media firm established; project plan and timeline; quarterly reports.

Activity 3. Develop strategy to use newborn screening card to conduct breastfeeding surveillance.

Output(s). Strategic plan; implementation timeline.

Monitoring. Quarterly reports.

Activity 4. Establish Baby Cafés in Georgia to support WIC and non-WIC participants and mothers of children with special health care needs.

Output(s). # of Baby Cafés in Georgia; # of clients served; # of families of infants/children with special health care needs served.

Monitoring. Implementation plan and timeline; contract/procurement developed.

Activity 5. Expand WIC Peer Counseling program to include all 18 public health districts and two contracted WIC sites.

Output(s). # of peer counselors; % of districts/contracted sites with participating in program; # of clients who receive peer counseling services.

Monitoring. Survey applicable public health districts' willingness to implement peer counseling program; Quarterly reports.

Activity 6. Develop strategy, implementation plan, and timeline for establishing a mother-friendly worksite program in Georgia.

Output(s). Guidelines for new program; applicants to become mother-friendly; # of mother-friendly worksites; # of attendees at stakeholder meetings; # of stakeholder meetings.

Monitoring. Meeting notes; implementation plan and timeline; quarterly reports.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	95	97	98.6	98.7	99.1
Annual Indicator	95.6	98.5	94.5	99.0	99.1
Numerator	136479	140201	140201	127191	122773
Denominator	142750	142322	148403	128532	123912
Data Source				Newborn Hearing Program Data	Newborn Hearing Program Data
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	2011	2012	2013	2014
Annual Performance Objective	99.5	99.5	99.5	99.9	99.9

Notes - 2009

The denominator is the number of eligible births reported by the hospital, which equals live births minus newborn deaths, minus refused screening, minus transferred out without screen, plus transferred in without screen. The numerator is the number of births screened. It is common that

hospitals report that they screen more births than are eligible and then have a report of screening over 100% of their births. The data reported adjusts for over reporting screening by not allowing any hospital to go over 100%.

The annual performance objectives reflect Georgia's goal and belief that 100% of all newborns should receive a hearing screen prior to hospital discharge.

a. Last Year's Accomplishments

Screened 99% of all newborns prior to discharge from birthing hospitals, with a statewide referral rate of 3%.

Filled the UNHSI Coordinator position with a pediatric audiologist.

Awarded a contract to a second pediatric audiologist to assist with SendSS Newborn and other programmatic development activities.

Updated list of pediatric audiologists in Georgia.

Developed an email distribution list to facilitate UNHSI communication.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continuing to analyze quarterly hospital hearing screening data to identify hospitals with unsatisfactory screening and referral performance.			X	
2. Continuing to promote UNHSI.				X
3. Providing training and technical assistance to hospitals and other health care providers screening newborns.				X
4. Developing data system to link newborn hearing screening information with electronic birth certificate.				X
5. Providing technical assistance to Children 1st and UNHSI Follow Up Coordinators in health districts to link with children identified through screening reports from hospitals and other healthcare providers.				X
6. Developing the UNHSI module in SendSS and providing access to healthcare providers statewide.				X
7.				
8.				
9.				
10.				

b. Current Activities

Screened 99% of all newborns prior to discharge from birthing hospitals, with a statewide referral rate of 3%.

Hired UNHSI Follow-Up Coordinators in all 18 health districts. Trained district coordinators on UNHSI guidelines and protocols.

Implemented the UNHSI module of SendSS NB, resulting in a statewide surveillance and tracking system that is consistent across all health districts.

Conducted site visits to hospitals in several health districts to provide training and increase

hospital compliance with UNHSI screening protocols and quarterly reporting.

Received supplemental Health Resources and Services Administration (HRSA) grant funding. Grant activities focus on reducing "lost to follow up" rates among Hispanic and low-income target populations.

Developing a state plan to address gaps in the UNHSI system.

c. Plan for the Coming Year

Activity 1. Provide professional development for pre- and postnatal families and healthcare professionals about newborn hearing screening (UNHSI) and the importance of follow-up hearing screening by disseminating information via multiple communication methods, including PSAs, the UNHSI brochure and web site, social networking sites, newsletter articles, and presentations.

Output(s). Type and number of materials distributed; number of newsletter articles written; number of presentations given; number of friends and networks on social networking sites.

Monitoring. Quarterly review of education activities. Bi-monthly monitoring and updates of social networking sites.

Activity 2. Improve the UNHSI system by developing and implementing a policy and procedure manual on early detection and intervention of children with suspected or confirmed hearing loss for hospitals, audiologists, and program staff.

Output(s). Revised policy and procedure manual available in print and electronically on website.

Monitoring. Quarterly review and discussion regarding progress at stakeholder meeting; ensure distribution to appropriate providers and availability of UNHSI website.

Activity 3. Reduce the percentage of babies who are lost to follow-up.

Output(s). Quarterly comparison of differences between the number of births reported through the hearing screening system and the number of births registered, by hospital; summary of discussions with Vital Records and the outcomes; documentation of education, TA, and training activities provided to hospitals.

Monitoring. Quarterly meetings to review hospital and vital records data and discuss outcomes of meetings with Vital Records and the education, TA, and training activities provided to hospitals.

Activity 4. Develop and pilot a data entry screen in SendSS for hospitals to manually enter hearing screening results.

Output(s). Module developed; pilot sites' evaluations of the data entry screen.

Monitoring. Bi-monthly meetings to discuss progress towards completion of the module; monthly reviews of the number of hearing screen results entered into SendSS.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and	2005	2006	2007	2008	2009
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Performance Data					
Annual Performance Objective	13	12	11.7	13.2	11.7
Annual Indicator	11.8	11.8	11.5	10.5	10.9
Numerator	294084	294084	288837	265593	282487
Denominator	2497888	2497888	2516819	2538435	2592540
Data Source				Current Population Survey	Current Population Survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	10.8	10.8	10.7	10.6	10.6

Notes - 2009

For the FY11 submission, the data source was changed to the Current Population Survey (http://www.census.gov/hhes/www/cpstc/cps_table_creator.html). Data for 2009 are not available. These data will be available with the release of data for the 2010 Current Population Survey. For 2009, data were estimated using a linear projection with data from 2002 through 2008.

Data were updated for 2007, 2008, and 2009.

Annual performance objective estimates are developed by applying the average annual percent change (-0.6%) between 2002 through 2009 to the 2009 point estimate.

a. Last Year's Accomplishments

Assessed health care coverage of all clients referred to CMS programs.

Assisted eligible CMS clients with insurance applications.

Collaborated with other CSN programs to ensure each child received a health care need assessment.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Providing training, technical assistance and monitoring of Grant-in-Aid (GIA) annex deliverables related to PeachCare and Medicaid outreach, referral and administrative case management.				X
2. Continuing collaborations with DFCS and DCH to plan and coordinate "Cover the Uninsured Week" activities for teens throughout Georgia.				X
3. Providing training, technical assistance and monitoring of GIA annex deliverables related to assuring a medical home for all				X

children and adolescents and their families lacking insurance.				
4. Continuing to assist families during the Children 1st Family Assessment in completing necessary forms for enrollment in Medicaid or PeachCare for Kids.				
5. Sharing Medicaid and PeachCare for Kids information at community health fairs, training, exhibits, etc.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Continued to assess health care coverage for all CMS clients. As of the second quarter of State Fiscal Year 2010, of the 8,763 clients served in CMS, 67% were on Medicaid, 6% were enrolled in PeachCare for Kids, 12% had private insurance, 1% had TriCare, and 14% only had CMS.

c. Plan for the Coming Year

Activity 1. Monitor and report percentage of children without healthcare insurance by utilizing various sources of data.

Output(s). Child health insurance status report.

Monitoring. Quarterly progress reports.

Activity 2. Screen all children participating in MCH programs for eligibility for public insurance options and make appropriate referrals.

Output(s). Number of children screened; number of children referred.

Monitoring. Quarterly data reports.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		8.3	15	29	28
Annual Indicator	28.0	28.0	30.9	31.4	30.6
Numerator	27999	27999	31225	25994	23650
Denominator	99998	99998	101052	82782	77286
Data Source				PedNSS	PedNSS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	2011	2012	2013	2014

Annual Performance Objective	30.4	30.3	30.1	30	29.8
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Notes - 2009

Data from Georgia PedNSS report as provided by Georgia WIC. Data for 2008 were updated to reflect most currently available data.

The average annual percent change between 2000 and 2008 is an increase of 2.4%. While there was a decrease between 2008 and 2009, this was the first decrease between 2000 through 2009. The annual performance objective will be set for a 0.5% decline in each year through 2014.

Notes - 2007

Data is an average of 2005 data available. CY 2006 data is not yet available.

a. Last Year's Accomplishments

Provided training and technical assistance to state and health district staff on a variety of nutritional topics.

Provided nutritional training for WIC participants.

Updated WIC Food Packages to offer more healthy (particularly lower in fat and sugar) food choices.

Facilitated integration of client-centered nutrition counseling techniques.

Assisted with establishment and promotion of Fit WIC program.

Instituted electronic data collection fields related to nutrition and physical activity practices in updated nutrition assessment forms.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Providing individual counseling to WIC participants on a variety of nutrition topics addressing healthy weight (i.e., healthy eating, stress-free feeding, and physical activity).	X			
2. Providing group nutrition education to WIC participants through healthy eating and physical activity programs (i.e., Magic Bag program, FUN Club, healthy cooking demonstrations).	X			
3. Providing training to WIC staff on addressing childhood obesity using a public health approach.		X		
4. Collaborating with DCH to provide Lunch and Learn sessions with private providers and share information about services available to Medicaid and PeachCare for Kids eligible children.		X		
5. Providing quality assurance site visits to the private sector to assure Health Check services to children are provided appropriately.				X
6. Collaborating with DCH, DFCS, GA-AAP to ensure children who are in state custody foster care receive appropriate health services through the Medicaid program.		X		
7. Continuing cross-team collaboration to assure children who are eligible for Medicaid and PeachCare receive available services, i.e., CMS case management, BCW, Children 1st, AHYD, and PRS.				X

8. Monitoring by chart review during Health Check site visits if further evaluation or parent counseling is required.				X
9.				
10.				

b. Current Activities

With assistance of WIC epidemiologists, revising WIC participant assessment form questions regarding nutrition and physical activity practices to ensure accurate, consistent, measurable data collection.

Promoting the redemption and use of the new healthier WIC food packages by the Georgia WIC population.

Designing an evaluation methodology for Georgia Fit WIC pilot.

c. Plan for the Coming Year

Activity 1. Develop a plan for implementation of the Operation Frontline chef-led volunteer nutrition and food program in WIC clinics.

Output(s). Strategic plan developed for future implementation.

Monitoring. Committee formed to develop plan; committee attendance; meeting notes; attendance rosters.

Activity 2. Establish comprehensive obesity-related risk behavior data surveillance system through Georgia's WIC electronic child and adult nutrition assessment forms.

Output(s). System upgrades to allow for a pilot of updated child and adult nutrition assessment forms' obesity-related risk behavior questions.

Monitoring. Quarterly reports.

Activity 3. Implement Fit WIC in all 18 public health districts and two contracted WIC sites.

Output(s). # of clients served; # of participating public health districts/contracted sites.

Monitoring. Quarterly reports.

Activity 4. Develop and implement a survey to evaluate the prevention, assessment, and treatment of childhood obesity in pediatric practices statewide.

Output(s). Report of pediatricians, family physicians, and other pediatric healthcare providers' statewide practices involving the prevention, assessment, and treatment of childhood obesity.

Monitoring. Quarterly reports; draft survey instrument.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance	2005	2006	2007	2008	2009
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Data					
Annual Performance Objective		8.2	10.2	10.1	9.2
Annual Indicator	8.4	8.4	10.3	8.2	7.6
Numerator	10783	10783	13818	12821	12225
Denominator	128078	128078	134114	155725	160148
Data Source				PRAMS	PRAMS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	7.4	7.2	7	6.9	6.7

Notes - 2009

PRAMS data are not available for 2007, 2008, or 2009. These data have been estimated using a linear projection with PRAMS data from 2004 through 2006. While PRAMS is a sample survey, the numerator is estimated by multiplying the rate from PRAMS and the total number of pregnancies in the year. Pregnancy data are available through 2007. Pregnancies for 2008 and 2009 are estimated using a linear projection.

There are insufficient data to project the annual performance objectives based on previous data. The annual performance objectives were estimated using an annual decline of 2.5%.

a. Last Year's Accomplishments

Promoted preconception health screening.

Disseminated educational materials in English and Spanish to community partners.

Referred pregnant women who smoke to Georgia Tobacco Quit Line.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conducting statewide perinatal center training in 13 of 18 public health districts.				X
2. Continuing Council on Maternal and Infant Health participation in regional perinatal center activities.				X
3. Providing preconception health counseling to family planning clients.	X			
4. Continuing to provide perinatal case management training.				X
5. Continuing to promote interconceptional periods of at least 1 ½ to 2 years.	X			
6. Continuing work with Tobacco Section on tobacco use prevention and cessation for maternal clients.				X
7. Working with regional tertiary hospitals to improve communication in the community.				X
8. Collaborating with March of Dimes for premature clients, working with community and private providers.				X

9. Continuing to collaborate with WIC on activities to improve communication with clients receiving services from Women's Health and WIC.				X
10.				

b. Current Activities

Collaborated with the Georgia Tobacco Quit Line on the development of a case management module for women who smoke during pregnancy.

c. Plan for the Coming Year

Activity 1. Partner with health departments, women's health coordinators, youth development coordinators, family planning clinics and WIC to increase awareness of the impact of smoking during pregnancy.

Output(s). # of brochures and posters on the impact of smoking during pregnancy disseminated to family planning clinics, health departments, and WIC clinics.

Monitoring. Quarterly reports.

Activity 2. Collaborate with the Georgia Obstetrical and Gynecological Society to increase provider and pregnant patient awareness of the Georgia Tobacco Quit Line.

Output(s). # of calls to Quit Line; # of providers trained; # referrals to Quit Line; # of materials distributed to providers; # of hits to the Georgia Tobacco Quit Line website.

Monitoring. Quarterly reports.

Activity 3. Develop and implement a health education campaign targeting pregnant women in public health districts with high rates of tobacco use.

Output(s). # brochures distributed; # of billboards erected; # of posters distributed; # PSAs developed.

Monitoring. Quarterly reports.

Activity 4. Implement the Tobacco Cessation Fax Back Program in 25% of local public health departments as a part of Family Planning Services tobacco use assessment intake procedures.

Output(s). Number of local public health departments that implement the fax back program; # of calls to the Georgia Tobacco Quit Line; # of faxes to Georgia Tobacco Quit Line.

Monitoring. Quarterly reports

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures

[Secs 485 (2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	7.7	7.7	4.5	5.4	4.5
Annual Indicator	4.6	4.6	4.6	4.6	4.3
Numerator	30	30	31	32	30

Denominator	646904	646904	679005	689623	702781
Data Source				Vital Records	Vital Records
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	4.2	4.1	4	3.9	3.8

Notes - 2009

Data were updated for 2007, 2008, and 2009.

Data are unavailable for 2008 and 2009. The provisional estimates are developed using a linear projection with data from 2000 through 2007. Population data provided by the Georgia Online Analytic Statistical Information System. Population data for 2009 are estimated using a linear projection with data from 2000 through 2008.

The average annual percent change is -2.3%. This is applied to the 2009 projected rate of 4.3 to project the annual performance indicator for 2010 through 2014.

a. Last Year's Accomplishments

Disseminated statewide directory of mental health resources to state agency, health district, and community partners.

Monitored Grant-in-AID (GIA) deliverables related to adolescent mental health and wellness.

Provided education to state and local staff to increase awareness of suicide prevention strategies and prevalence of suicide among youth.

Worked with the Family Health Mental Health Program Specialist and School Health Coordinator to assess training and technical assistance needs, identify information and resource sharing opportunities, and assure collaboration with other state agencies and community partners regarding best practice research and national and state priorities and youth suicide trends.

Collaborated with Injury Prevention on suicide initiatives.

Collaborated with the state Suicide Advisory Committee on suicide awareness initiatives.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Providing training, technical assistance and monitoring of district activities and progress related to suicide prevention plans and objectives.				X
2. Continuing collaborations with the Department of Behavioral Health, Office of Injury Prevention, Aging and other agency staff in the development of a state suicide prevention plan that				X

includes staff development and distribution of statewide listings				
3. Continuing development of MCH referral, intake, and assessment processes to identify adolescents “at risk” and to assure timely receipt of appropriate mental health resources.				X
4. Continuing to develop outcome and contract requirements, performance expectations/indicators, and policies and procedures for contracts and Grant-in-Aid annexes related to adolescent mental health and wellness.				X
5. Continuing funding and implementation of youth development programs and activities that provide adult supervised activities, caring adult mentors, and peer educators for targeted youth.			X	
6. Providing training and technical assistance to the Georgia Association of School Nurses and other school health professionals to provide training and technical assistance related to suicide prevention.				X
7. Providing information to CMS staff on identification and referral of at-risk clients.				X
8.				
9.				
10.				

b. Current Activities

Monitored Grant-in-AID (GIA) deliverables related to adolescent mental health and wellness.

Provided education to state and local staff to increase awareness of suicide prevention strategies and prevalence of suicide among youth.

Collaborated with Injury Prevention on suicide initiatives.

Collaborated with the state Suicide Advisory Committee on suicide awareness initiatives.

c. Plan for the Coming Year

Activity 1. Work with the Georgia Violent Death Reporting System to produce an age range specific fact sheet and map with overlay of high schools for distribution to the school systems.

Output. Production of fact sheets.

Monitoring. Quarterly progress reports; draft fact sheets.

Activity 2. Follow up on survey of existing protocols in high schools regarding suicide ideation and attempts.

Output(s). Redistribute survey and compare results; report results.

Monitoring. Survey validation report; plan for survey implementation.

Activity 3. Review report on child deaths resulting from suicide completions through Child Fatality Review and develop policy recommendations and activities aimed at reducing such deaths.

Output Measure(s). Annual Child Fatality Review Team Report on child deaths that includes suicide deaths and policy recommendations.

Monitoring. Quarterly reports.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	76	76.5	77	77.5	70
Annual Indicator	74.9	74.9	73.1	73.6	73.0
Numerator	1920	1920	1931	1974	2008
Denominator	2563	2563	2641	2681	2750
Data Source				Vital Records	Vital Records
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	73.4	73.7	74.1	74.5	74.8

Notes - 2009

Georgia has five perinatal levels. Level 0 has no delivery capacity. Level I is basic care. Level II is specialty care. Level III is subspecialty care. Level IV is the state designated perinatal centers. Level I through III are self-designated at the time of application for Certificate of Need. Facilities for high-risk deliveries and neonates are defined as Level III and IV facilities.

Data were updated for 2007, 2008, and 2009.

Data are unavailable for 2008 and 2009. The provisional estimates are developed using a linear projection with data from 2000 through 2007.

The average annual percent change for this indicator is -0.7%. With an expectation to improve this indicator, the annual performance objective reflects a 0.5% increase in the 2009 percent.

a. Last Year's Accomplishments

Encouraged screening, early identification, and management of risk factors in first trimester of pregnancy or as appropriate.

Encouraged referral of high-risk patients to tertiary care facilities.

Supported transfer of high-risk neonates to risk-appropriate care facilities through Maternal and Infant contracts.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conducting annual performance audits at each regional				X

center.				
2. Working on outreach education plans at all regional perinatal centers.				X
3. Focusing perinatal case management (PCM) training on pre-term delivery prevention.				X
4. Continuing to work with the OB/GYN Society on increasing the number of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.				X
5. Conducting bi-annual regional perinatal center clinical peer reviews.				X
6. Referring all high-risk Babies Born Healthy program participants to regional perinatal centers.			X	
7.				
8.				
9.				
10.				

b. Current Activities

Collaborated with the Division of Healthcare Facility Regulations and the Division of Medical Assistance (Medicaid) to explore ways to promote delivery of high-risk patients at risk-appropriate level of care facilities.

Updating the Georgia Guidelines for Perinatal Care.

c. Plan for the Coming Year

Activity 1. Conduct a perinatal capacity survey of designated Level II and Level III facilities in the state.

Output(s). Number of completed surveys; analysis of surveys; development and dissemination recommendations from analysis.

Monitoring. Survey response and completion rates; Completion of analyses; Engagement of stakeholders.

Activity 2. Develop a survey for Level I facilities in the state.

Output(s). A completed survey draft; a completed review of the survey by subject matter experts; a pilot of the survey conducted.

Monitoring. A survey drafted; subject matter experts identified and engaged; implementation of pilot survey.

Activity 3. Provide an analysis of delivery in high risk facilities of high risk mothers using birth record data and GIS technology.

Output(s). A map identifying delivery patterns; a report examining differences between women who deliver at high risk facilities and those who do not.

Monitoring. Quarterly reports.

Activity 4. Meet with Georgia Obstetrical and Gynecological Society, neonatologists, perinatologists, leadership from the Regional Perinatal Centers, and other appropriate stakeholders to share research findings and develop a strategic plan to improve the percent of

deliveries performed at appropriate sites.

Output(s). Strategic plan to improve delivery choice sites.

Monitoring. Number of people invited to participate; identification of appropriate meeting participants; accepted responses to meeting invitations.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	86.3	86.5	86.8	87	64.5
Annual Indicator	81.2	81.2	63.9	71.3	69.7
Numerator	114459	114459	96662	108359	107830
Denominator	140903	140903	151303	152004	154745
Data Source				Vital Records	Vital Records
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	70	70.4	70.8	71.1	71.5

Notes - 2009

In 2007, Georgia adopted the 2003 Revised Birth Certificate part way through the year. This had two impacts on NPM18. First, it changed how the entry into prenatal care question was asked from asking for month of entry into prenatal care to asking for date of entry into prenatal care. Second, the vitals reporting system changed. The impact of the first change is well described by National Center for Health Statistics. The impact of the second change was that the percent of women with unknown entry into prenatal care increased beyond what would be expected to happen from the wording change alone. In 2007, 22.5% of women were missing information necessary for calculating trimester of entry into prenatal care. The denominator is all births. If the denominator was limited to only those who had valid data, the rate in 2007 (the last year for which actual data exist) would be 82.7% (96,662/116,941).

Data from 2007, 2008, and 2009 were updated.

Data are unavailable for 2008 and 2009. The provisional estimates are developed using a linear projection with data from 2000 through 2007. Given the changes in this measure, the linear projections may be less reliable than in other measures.

Given the current volatility of this measure, projecting the annual performance measure is challenging. Based on the projected rate in 2009, the annual performance measure reflects a 0.5% increase in this measure annually.

a. Last Year's Accomplishments

Continued to provide care to uninsured low income women through the Babies Born Healthy program.

Promoted bilingual patient education.

In collaboration with the Department of Community Health's Medical Assistance Division and Georgia Families (Medicaid) Care Management Organizations (CMOs), developed and implemented a rapid process improvement pilot project in DeKalb County to improve the enrollment process for pregnant women in their first trimester of care.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continuing to provide referrals to private OB providers, WIC and Medicaid for all clients enrolled in PCM.			X	
2. Providing Family Planning staff with opportunities to attend PCM training to learn about the importance of early entry into prenatal care.				X
3. Enrolling uninsured/underinsured, low-income pregnant women ineligible for Medicaid in Babies Born Healthy program.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Worked with the Division of Medical Assistance (Medicaid) to improve timely enrollment of pregnant women with a CMO and entry into first trimester prenatal care.

c. Plan for the Coming Year

Activity 1. Convene meeting with Georgia Obstetrical and Gynecological Society, Georgia Academy of Family Physicians, Georgia Chapter of American College of Nurse Midwives, and Care Management Organizations to discuss barriers to prenatal care beginning in first trimester.

Output(s). List of barriers to early entry into prenatal care beginning in the first trimester; develop plan to address barriers.

Monitoring. # of invitations issued; # of invitees who accepted invitation; # of invitees who attended the meeting; # of meetings.

Activity 2. Partner with stakeholders to fund Centering Pregnancy Projects.

Output(s). # of sites funded; # of patients served; evaluation report.

Monitoring. Monthly reports of # of clients enrolled; submission of data forms.

D. State Performance Measures

State Performance Measure 1: *Percentage of very low birth weight babies enrolled in High Risk Infant Follow-Up (HRIFU)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		21	23	25	27
Annual Indicator	18.5	23.3	12.3	10.7	11.7
Numerator	356	448	341	299	335
Denominator	1920	1920	2780	2798	2867
Data Source				Fist Care Program Data	First Care Program Data
Is the Data Provisional or Final?				Final	Final
	2010	2011	2012	2013	2014
Annual Performance Objective	29	30	30	30	

Notes - 2009

The numerator is collected through program specific reports submitted by each public health district. The denominator is the number of very low birth weight infants born in Georgia. Denominator data are not available for 2008 and 2009. A projection is used developed using a linear trend with data from 2000 through 2007.

Notes - 2007

The numerator is from FY2005 data and the denominator is from 2004 infant birth-death linked data. The denominator is all VLBW births minus VLBW births that died within the first week of life.

a. Last Year's Accomplishments

Monitored the impact of CMOs on enrollment and services for families with high risk infants.

Developed and implemented a "state of the HRIFU program" survey to inform planning activities.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Georgia's HRIFU program was eliminated in FY 2009 due to state budget cuts. Children who would qualify for services under this program are now referred to Children 1st and other services as appropriate.			X	
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Georgia's HRIFU program was eliminated in FY 2009 due to state budget cuts. Children who would qualify for services under this program are now referred to Children 1st and other services as appropriate.

c. Plan for the Coming Year

This measure will be retired.

State Performance Measure 2: *Percentage of high school students who participated in physical activity for at least 20 minutes on 3 or more of the past 7 days*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		65	66	67	68
Annual Indicator	61	61	63.9	63.9	63.5
Numerator			289698	294130	296554
Denominator			453361	460298	467235
Data Source				YBRS	YRBS
Is the Data Provisional or Final?				Final	Final
	2010	2011	2012	2013	2014
Annual Performance Objective	69	70	71	71	

Notes - 2009

The Georgia YRBS survey, conducted in odd years since 2003, is the data source for this measure. The survey question related to physical activity changed between the 2003 and 2005 survey years. In 2003: Percentage of those who reported 20 minutes of vigorous activity and/or 30 minutes of moderate activity on 3 or more of the past 7 days completed. In 2005-2009: Percentage of those who reported any physical activity for at least 60 minutes on 3 or more of the past 7 days.

Denominator data from 2005-2006 K-12 Public Schools Annual Report Card (<http://reportcard2006.gaosa.org/k12/demographics.aspx?ID=ALL:ALL&TestKey=EnR&TestType=demographics>). All data reflect Fall enrollment except for 2006 which reflects Spring enrollment. Data for 2007, 2008, and 2009 are estimated with a linear projection methodology using data from 2003 through 2006.

This measure will be retired.

Notes - 2008

A numerator and denominator is not available for this percentages. Source: OASIS

Notes - 2007

Data is from the GA School Health Survey (YRBS). The survey is conducted every other year and the latest data available is for 2005. The data does not include numerator and denominator.

a. Last Year's Accomplishments

Disseminated Nutrition Unit electronic newsletter to provide service providers of children with information on the importance of partnering with the Unit to influence school-aged children to become more physically active.

Assisted the Georgia Obesity Team and external partners in education efforts to support passage of HB-229, the Student Health and Physical Education (S.H.A.P.E.) Act. The bill passed during 2009 Georgia Legislative Session.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Partnering with the Obesity team (via steering committees), which continues to educate local parks about adoption of Georgia Recreation and Park Association resolution as a policy.				X
2. Providing and tracking technical assistance to local school districts on developing local wellness policies.				X
3. Providing technical assistance to Nutrition and Physical Activity grantees on implementing and evaluating nutrition and physical activity initiatives.				X
4. Disseminating results of PROFILES.				X
5. Disseminating Physical Activity Report.				X
6. Disseminating Walk to School Report.				X
7. Monitoring, evaluating and providing feedback to Waycross and Augusta Nutrition and Physical Activity projects.				X
8.				
9.				
10.				

b. Current Activities

Filled CDC-funded nutrition coordinator, physical activity coordinator, health education specialist, and epidemiologist positions.

Held Healthy School Summit in March 2010 that focused on quality physical activity, school nutrition programs, healthy school environments, family and community involvement and health promotion programs for school staff.

Partnered with the Georgia Coalition for Physical Activity and Nutrition (GPAN) to implement Operation Frontline (OFL-GA), to target disparate populations.

Working with the Department of Education on the development of Fitness Assessment training as part of Student Health and Physical Education Act (HB 229) activities.

Provided funding to local health departments to implement physical activity and nutrition policy, systems, and environmental interventions.

Implemented 2009-2010 Healthy School Award process. Winning schools will be selected in June 2010.

c. Plan for the Coming Year

This measure will be retired.

State Performance Measure 3: *Rate of hospitalizations due to unintentional injuries among children ages one through age four.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
---------------------------------------	------	------	------	------	------

Annual Performance Objective		174	173	173	172
Annual Indicator	191.0	191.0	76.0	90.5	89.0
Numerator	1050	1050	444	531	538
Denominator	549882	549882	584503	586783	604732
Data Source				Hospital Discharge Data	Hospital Discharge Data
Is the Data Provisional or Final?				Provisional	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	172	171	171	170	

Notes - 2009

Inpatient discharges with E-codes E810-825, E880-888, E922, E910, E890-899, E850-869, and E924.1 for years 2000-2007. Data accessed through OASIS.

Injuries included: Motor Vehicle Crashes, Falls, Accidental Shooting, Drowning, Fire and Smoke Exposure, and Poisoning.

Data are unavailable for 2008 and 2009. The provisional estimates are developed using a linear projection with data from 2000 through 2007. Population data provided by the Georgia Online Analytic Statistical Information System. Population data for 2009 are estimated using a linear projection with data from 2000 through 2008.

Data are reported per 100,000.

This measure will be retired.

a. Last Year's Accomplishments

Provided child passenger safety training, technical assistance, and monitoring activities.

Distributed child safety seats throughout Georgia to those in need.

Provided education to parents and other caregivers on child passenger safety and how to correctly install car seats.

Installed smoke detectors in high-risk households in Georgia.

Provided fire safety education to high-risk households in Georgia.

Worked with communities to increase the use of infant safe sleep practices to reduce suffocation and other sleep related deaths.

Provided technical assistance to Safe Kids Georgia and its local coalitions on strategies to prevent unintentional injuries and unintentional injury-related deaths to youth 14 years of age or younger.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Providing training, technical assistance, and monitoring regarding activities related to child passenger safety activities.		X		X

2. Distributing child safety seats with child passenger safety education.			X	
3. Installing smoke detectors with fire safety education.			X	
4. Working with communities on infant safe sleep practices to reduce suffocation and other sleep related deaths.		X		
5. Collaborating with the Injury Prevention Section and Office of Child Fatality Review.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Provided child passenger safety training, technical assistance, and monitoring activities.

Distributed child safety seats throughout Georgia to those in need.

Provided education to parents and other caregivers on child passenger safety and how to correctly install car seats.

Installed smoke detectors in high-risk households in Georgia.

Provided fire safety education to high-risk households in Georgia.

Worked with communities to increase the use of infant safe sleep practices to reduce suffocation and other sleep related deaths.

Provided technical assistance to Safe Kids Georgia and its local coalitions on strategies to prevent unintentional injuries and unintentional injury-related deaths to youth 14 years of age or younger.

c. Plan for the Coming Year

This measure will be retired.

State Performance Measure 4: *Percent of Medicaid and PeachCare (S-CHIP) enrolled children who received preventive oral health services.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		33	34.3	34.4	40
Annual Indicator	38.2	38.2	38.2	38.2	38.2
Numerator	538972	538972	538972	538972	538972
Denominator	1412423	1412423	1412423	1412423	1412423
Data Source				Unavailable	Unavailable
Is the Data Provisional or Final?				Provisional	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	40	40	40	40	

Notes - 2009

The data reported for this measure has not been updated since the initial report in 2005. These data are not available. This measure will be retired.

Notes - 2008

Per the Georgia Health Policy Institute, Medicaid/SCHIP data has not been received from the CMOs since they started in July 2006. Data reported is FY 2005 data. Data still is not available

Notes - 2007

Per the Georgia Health Policy Institute, Medicaid/SCHIP data has not been received from the CMOs since they started in July 2006. Data reported is FY 2005 data.

a. Last Year's Accomplishments

Offered school-based preventive dental services such as sealants, fluoride varnish and rinses, dental screenings and referrals in all 18 health districts, as well as comprehensive dental care. First priority was given to children who needed emergency dental services and who were eligible for the Free and Reduced Meal Program (185% Federal Poverty Level).

Successfully expanded the school sealant program by using 14 dental hygiene programs in the state.

Created networks with the dental hygiene programs, district dental staff, and volunteer providers, which expanded the ability to serve more children. In one day in February 2010, county staff, Oral Health Unit staff, and dental hygiene faculty and staff placed 244 sealants, performed 81 cleanings, completed 175 varnish applications, and provided 842 children with oral health education as part of the "Give Kids A Smile Day." United Concordia Insurance supported "Give Kids A Smile Day" activities. In addition, the insurance company provided the Oral Health Unit with sealant supplies for use in school-based sealant programs.

Provided dental training to school nurses and Heathy Start Directors.

Coordinated an HIV continuing education event for oral providers to offer updates on medications and the medical and dental needs of oral health patients who are HIV positive.

Disseminated information to the public health districts on special needs children and their oral health needs, special concerns, and medical considerations.

Implemented CDC-funded State-Based Oral Disease Prevention Program Phase I activities to strengthen the state's infrastructure and capacity to plan, implement, and evaluate population-based prevention and promotion programs.

Received 128 community water plant CDC Water Fluoridation Quality Awards.

Provided 138,608 children in FY 2009 with dental prevention and treatment services through health department dental clinics and visits to schools and child care facilities in Georgia.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Visiting elementary schools to conduct screenings on children, place sealants when needed, and provide prevention services, education, and fluoride treatments.	X			
2. Continuing provision of technical assistance and monitoring to district mobile dental trailer program to provide fillings and minor oral surgery services at elementary school sites.		X		

3. Continuing implementation of statewide surveys that measure oral health status and continuation of infrastructure building through grant funded school district projects.				X
4. Continuing statewide sharing of Best Practices developed through GADS projects.		X		
5. Continuing to provide ongoing consultative support and technical assistance to the districts.				X
6. Continuing efforts to adjust salaries for district dental clinical staff.				X
7. Continuing efforts to build and strengthen infrastructure through school-based/linked program expansion (total of 11 trailers and 2 vans).				X
8. Continuing trainings for school and public health nurses on oral disease prevention and how to provide dental screenings.				X
9. Evaluating access to care for Medicaid/PeachCare enrolled children through Georgia Health Policy contract to analyze claims data.		X		
10. Building community and professional collaborations that increase access to care and support Georgia Oral Health Program.				X

b. Current Activities

Hired an Oral Health Evaluator, Epidemiologist, Dental Sealant and Education Specialist, and Fluoridation Specialist with CDC funding as infrastructure support for enhancing, expanding and supporting oral health programs in Georgia.

Completed State Sealant Plan and Surveillance Plan.

Developing an oral health burden report and Community Water Fluoridation Plan.

Collaborated with the stakeholders on fluoride varnish reimbursement for young children under the Medicaid fee for service plan. The reimbursement includes twice a year treatment for children ages 1 month to 13 years 11 months.

Provided pregnant women receiving Medicaid with dental care.

Received 159 community water plant CDC Water Fluoridation Quality Awards.

Purchased two new mobile dental clinics that serve Lawrenceville and Waycross Health Districts.

Through the Medical College of Georgia School of Dentistry HRSA Workforce Development Grant, providing public health dental clinic internships to senior dental students to provide care in communities with disparities in oral health access.

Held quarterly meetings of the Georgia Oral Health Coalition.

Presented at the annual Georgia School Nurse Association (GSNA) annual 2010 session. GSNA has committed to supporting the School Sealant Program and third grade survey beginning in Fall 2010.

Developed an oral health Youth Risk Behavior Survey (YRBS) module for inclusion in the 2009 survey. The module will be implemented every two years.

c. Plan for the Coming Year

This measure will be retired.

State Performance Measure 5: *Percent of women of reproductive age who consume at least 400mcg of folic acid daily*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		45	46	47	48
Annual Indicator	45.3	45.3	46.2	46.2	46.2
Numerator			862992	865096	880049
Denominator			1866333	1870883	1903221
Data Source				BRFSS	BRFSS
Is the Data Provisional or Final?				Final	Final
	2010	2011	2012	2013	2014
Annual Performance Objective	49	50	50	50	

Notes - 2009

BRFSS is the data source for this measure. Women of reproductive age is defined as 18-44 years. The question used for this measure was asked only in 2000, 2002, and 2006, and is the percent of women who reported taking either a multivitamin or another pill or supplement containing folic acid. The amount of folic acid contained in the pills or supplement was not collected.

The 2006 point estimate was reported in 2007, 2008, and 2009 and applied to 2007, 2008, and 2009 population to calculate the denominator. The 2009 population estimate was developed with a linear projection with data from 2000 through 2008.

This measure will be retired.

Notes - 2008

2006 is the most recent year that Georgia included the folic acid module in BRFSS.

Notes - 2007

2006 is the most recent year that Georgia included the folic acid module in BRFSS. A numerator and denominator were not provided.

a. Last Year's Accomplishments

Through state-level nutrition consultants, promoted importance of consuming folic acid rich foods and/or taking a supplement at the State Office Building (houses Department of Human Resources and Department of Community Health) during National Folic Acid Awareness week.

Promoted counseling on the importance of adequate daily folic acid consumption with women of reproductive age who participate in the Georgia WIC program.

Engaged external partners (e.g., March of Dimes) participating in the informal Maternal and Child Health Nutrition Council by providing general advisement on the nutritional importance of adequate folic acid consumption. Also brainstormed ideas to build infrastructure within Georgia to support provision of evidence-based nutrition counseling (i.e., folic acid and Omega-3 fatty acid consumption) for women of reproductive age that complements WIC program activities.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Participating in statewide WIC Clinical Nutrition trainings.				X
2. Leading the Maternal and Child Health Nutrition Advisory Council, which promotes the importance of adequate daily consumption of folic acid.				X
3. Seeking infrastructure building opportunities to implement folic acid supplementation and nutrition education programs as a complement to the Georgia WIC program.			X	
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Provided folic acid supplements to all women of reproductive age receiving Family Planning services who have not completed their family.

Presented MCH Nutrition Advisory Council strategies to the state-level Birth to Five Committee to help facilitate a comprehensive approach to Georgia's MCH intervention work.

c. Plan for the Coming Year

This measure will be retired.

State Performance Measure 6: Percent of repeat births among adolescents aged 15-17-years-old

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		10.6	10.6	10.5	10.5
Annual Indicator	9.9	9.9	11.1	10.1	9.9
Numerator	522	522	639	550	537
Denominator	5260	5260	5756	5452	5419
Data Source				Vital Records	Vital Records
Is the Data Provisional or Final?				Provisional	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	10.4	10.4	10.4	10.4	

Notes - 2009

There are no data available for 2008 or 2009. Data for 2008 and 2009 are estimated using a linear projection with data from 2000 through 2007. Data were updated for 2007, 2008, and 2009. This measure will be retired.

a. Last Year's Accomplishments

Collaborated at the district level on joint Adolescent Health and Youth Development (AHYD) and Family Planning activities for Let's Talk Month (October) and Teen Pregnancy Prevention Month (May). The State Family Planning program required that activities be identified in district work

plans. Districts reported progress quarterly.

Provided Family Planning and AHYD technical assistance to districts on implementing activities to reduce repeat teen pregnancies.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Using data to target interventions.				X
2. Working closely with organizations and agencies that serve pregnant teens.				X
3. Continuing to refocus nontraditional sites to address repeat pregnancies.				X
4. Implementing and expanding parent education.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Collaborated with Health Promotion and Disease Prevention staff on joint AHYD and Family Planning activities for Let's Talk Month (October) and Teen Pregnancy Prevention Month (May).

Funded 27 teen centers programs in 26 counties with high rates of school dropouts, HIV/STDs, and/or teen pregnancy. During the first quarter of FY 2010, 8,681 youth received teen center services; 5,621 youth participated in 1,109 group sessions with a youth development focus; 4,315 public education events were conducted; and 7,216 physical health services were provided.

Funded a Youth Development Coordinator (YDC) in all 18 health districts. YDCs coordinate youth development activities between the district and county health departments. YDCs also form partnerships with out-of-school programs and county and community agencies as well as work with community faith and public health leadership to mobilize around key issues and healthy youth development. Funded AHYD program strategies and activities include programs for youth such as abstinence education, drug and alcohol prevention education, adolescent reproductive health services; parent educational seminars; and training programs designed to increase community awareness about teen pregnancy. District and county health departments actively partner with other local youth organizations/providers to co-sponsor events and to assure that youth have access to needed services and opportunities within their communities.

c. Plan for the Coming Year

This measure will be retired.

State Performance Measure 7: *Rate of SIDS among African American infants.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
---------------------------------------	------	------	------	------	------

Annual Performance Objective		1.2	1.2	1.1	1.1
Annual Indicator	1.2	1.2	1.7	1.5	1.6
Numerator	53	53	83	74	77
Denominator	45457	45457	48037	47951	48810
Data Source				Vital Records	Vital Records
Is the Data Provisional or Final?				Provisional	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	1	1	1	1	

Notes - 2009

Data are not available for 2008 and 2009. The provisional estimates are developed using a linear projection with data from 2000 through 2007. Data were updated for 2007, 2008, and 2009. This measure will be retired.

a. Last Year's Accomplishments

Identified and provided SIDS education to at risk populations as part of the overall assessments or evaluations completed at the time of entry into CYSN and CMS programs.

Held genetics clinics in five health districts outside of the metropolitan Atlanta area. During the clinics, infants who were at risk of SIDS (i.e., family history, children's medication condition) were identified and the infant's family was provided with SIDS education.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assisting parents of high risk infants to obtain cribs for infants when families do not have one.		X		
2. Teaching parents of high risk infants about safe infant sleeping positions.		X		
3. Securing and disseminating educational materials.		X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Provided SIDS risk reduction strategies and education to districts and community agencies.

Provided Crib Match program information and education to child serving agencies. Recruited agencies to participate in the program.

c. Plan for the Coming Year

This measure will be retired.

State Performance Measure 8: *Percentage of Medicaid children who have had a developmental screening*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		75	75	76	76
Annual Indicator			19.0	19.0	19.0
Numerator			161261	162472	166510
Denominator			848742	855116	876370
Data Source				National Survey of Children's Health	National Survey of Children's Health
Is the Data Provisional or Final?				Final	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	77	77	77	77	

Notes - 2009

Data are from the 2007 National Survey of Children's Health. This percent is repeated in 2008 and 2009. Percent includes any public insurance; not only those who receive Medicaid. Denominator is limited to children ages 10 months to 5 years only. Numerator and denominator are estimated using the percent reported from the 2007 National Survey of Children's Health. Denominator includes all children ages 1 to 5 years and 5/6 of all infants to proxy the number of children in their first year of life ages 10 months or older. The denominator for 2009 is an estimate developed using a linear estimation model with data from 2000 through 2008. This measure will be retired.

a. Last Year's Accomplishments

Adopted the Ages and Stages Questionnaire as the Division of Public Health's developmental screening tool for programs serving young children ages birth to five years.

Hired developmental specialists in all 18 health districts to assist with developmental screening and referrals.

Provided Birth to Five system training to state public health staff, stakeholders, and communities on use of Ages and Stages Questionnaire/ developmental screen and on how to refer children identified with concerns.

Determined the developmental screening status of children with suspected delay and provided referrals to Children 1st. The Birth to Five System completed a MCH Integrated Assessment for children who had received a standardized developmental screening. The screening results, assessment, and referral were forwarded to BCW. Birth to Five also completed the MCH Integrated Assessment and standardized developmental screening for children who had not received a standardized developmental screening.

Identified and provided SIDS education to at risk population as part of the overall assessments or evaluations completed at the time of entry to CYSN and CMS programs.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Providing education to support developmental screening.			X	
2. Working in collaboration with medical organizations, patient groups, and early childhood agencies to promote developmental screening.			X	
3. Monitoring by chart review during Health Check site visits.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Provided Ages and Stages Questionnaire-3 (ASQ3) and Ages and Stages Questionnaire/Social Emotional (ASQ: SE) train-the-trainer training statewide.

Developed a plan to carry forward ASQ3 and ASQ: SE training to key public health staff, community agencies, and state partners to help increase the number of children receiving developmental screening.

c. Plan for the Coming Year

This measure will be retired.

State Performance Measure 9: *The percent of MCH state and local public health staff that have completed the Public Health 101 course.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		8.5	9	9.5	10
Annual Indicator	8.2	8.2	8.2	8.2	8.2
Numerator	95	95	95	95	95
Denominator	1158	1158	1158	1158	1158
Data Source				Workforce Development	Workforce Development
Is the Data Provisional or Final?				Provisional	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	10.5	11	11	11	

Notes - 2009

The data reported for this measure has not been updated since the initial report in 2005. These data are not available and this initiative is no longer active. There is no method to determine the number of staff who previously completed this course. This measure will be retired.

Notes - 2008

This course has been internally developed and was initially provided during the past year. We are currently in pilot stage of the rollout which targets local level staff. Additional course offerings will be available for state office staff beginning during the next few months. We anticipate a significant increase in staff participation in the coming months and years.

Notes - 2007

The curriculum is being revised. Other courses were offered in the interim but full implementation of Public Health 101 will occur in the coming months and will be reported in the FY 2010 MCHBG.

a. Last Year's Accomplishments

Held Georgia Infant Mortality Summit in December 2008 with over 150 stakeholders in attendance.

Developed a train-the-trainer workshop on "Understanding and Implementing SB529 (verification of lawful presence in the U.S. for any person 18 years of age or older)" for public health districts and a self-paced training course for state office staff.

Revised educational materials to reflect changes made to DPH guidance on immigrant access to public health services.

Provided state and local staff training on SB529.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Providing training to state and district/county staff on various MCH nutrition and health related topics throughout the year.				X
2. Participating in local coalition development and sustainability (focusing on nutrition/physical activity/obesity related coalitions).				X
3. Providing technical assistance to health districts.				X
4. Providing training for Oral Health staff on infection control, disease management, computer systems, and programmatic management skills development. Continuing education credits are required for professional licensure.				X
5. Providing Public Health and School Nurses with dental screening training.				X
6. Providing training updates on Bright Futures Health Supervision Guidelines for Infants, Children and Adolescents during Health Check review visits.		X		
7. Providing training on Development Ages and Stages Questionnaire.		X		
8.				
9.				
10.				

b. Current Activities

There are no current activities associated with State Performance Measure 9. While general training occurs regularly within the MCH Program, there are no current efforts underway to promote staff completion of Public Health 101.

c. Plan for the Coming Year

This measure will be retired.

State Performance Measure 10: *The extent to which partnerships that support Early Childhood Comprehensive Systems (ECCS) are effective.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		60	65	70	75
Annual Indicator	57.1	68.6	68.6	71.4	50.0
Numerator	20	24	24	25	12
Denominator	35	35	35	35	24
Data Source				CCH Program	CCH Program
Is the Data Provisional or Final?				Final	Final
	2010	2011	2012	2013	2014
Annual Performance Objective	80	85	85	85	

Notes - 2009

These data are taken from the Georgia Early Childhood Comprehensive Systems (ECCS) grant, Performance Measure #30. In 2009, the Performance Measure scoring was changed from a total possible score of 35 to a total possible score of 24. The form requests a self-assessment on the following 8 criteria:

1. State Plan supported the capacity of pediatric care providers to better identify, treat, and refer children with developmental risks and delays.
2. State Plan provided for the education of front line providers – teachers, health care workers, school counselors and coaches, faith-based workers, and clinicians of all disciplines – to recognize mental health issues in mothers of infants and young children and for the identification of and wide dissemination of quality measurement and improvement tools that can be used by health and early childhood development professionals to assess and strengthen the social-emotional development of young children.
3. State Plan provides for collaboration between the State Maternal and Child Health program and Child Care office addressing the sustainability of their Healthy Child Care America 2000 Program.
4. State Plan addresses strengthening the quality of child care by widely disseminating and providing technical consultation support for the adoption of child care health and safety standards from the 2nd edition of Caring for Our Children.
5. State Plan provides for the development of affordable, high quality parenting education programs that prepare parents to promote optimal physical, social-emotional, and cognitive development in their children.
6. State Plan provides for the development of family support services that address the stressors impairing the ability of families to nurture and support the healthy development of their children.
7. State Plan provides for the refinement of current home visiting programs in keeping with the science-based findings from recent home visiting program evaluations.
8. State Plan provides for the support and encouragement of greater involvement of home visiting resources in the context of one-stop-shopping family resource centers.

This measure will be retired.

a. Last Year's Accomplishments

Supported a family support practice study to examine current family support practices and training for state agency personnel who provide services for young children and families; evidence-based best practices related to family support; and strengths, gaps, and barriers related to current practices and training in Georgia.

Populated the ECCS web-based clearinghouse to provide early childhood related information and

web-based links for consumers and for early childhood providers.

Funded expansion and training of navigator teams to provide community support for families with young children.

Continued efforts to strengthen partnerships around ECCS principles and elements and to improve the lives of young children and their families.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assisting DECAL in maintaining appropriate content of nutrition and physical activity web site.				X
2. Providing input and technical assistance on menu planning, general nutrition, and physical activity tools and training.				X
3. Providing leadership to ECCS grant, steering committee, and work groups.				X
4. Implementing MOUs/subcontracts for ECCS cross cutting activities (i.e., clearinghouse, developmental screening, training, and public awareness).				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Re-engaged ECCS Steering Committee partners and identified and invited new partners.

Developing an electronic survey tool to assess the current and potential contributions of ECCS partners related to each of the five ECCS component areas.

Developed partnerships with the CDC Learn the Signs, Act Early State Team and with KidsNet Georgia and its System of Care Part C Finance Work Group.

Braided ECCS funds with Part C stimulus funding to provide train-the-trainer scholarships for ECCS partners on ASQ-3 and ASQ: SE.

c. Plan for the Coming Year

This measure will be retired.

E. Health Status Indicators

Introduction

The 12 MCH health status indicators direct the work of the MCH Program and Division of Public Health in the following ways:

- Program development: The indicators inform and assist in directing MCH efforts such as the

MCH Program's preconception health initiative, consumer and provider education, health promotion materials, web site development, contracts with provider organizations, and newsletter articles.

- Program assessment and enhancement: Examples include updating of tertiary center core requirements, focusing on enhancement and improvement of outreach education and developmental follow-up of newborns.

- Resource allocation: Acquisition and distribution of resources such as child safety kits through Children 1st have been informed by the health status indicators. Initiatives such as FOCUS, a data-driven community approach to addressing infant mortality in selected counties, have also been guided by health status indicator data.

- Monitoring, technical assistance, and quality assurance: Key performance indicators of measures of program process performance and are linked to health status indicators through logic models and program plans. These measures are used as triggers for technical assistance and quality assurance.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	9.4	9.4	9.5	9.7	9.8
Numerator	13301	13301	14351	14696	15121
Denominator	140903	140903	150804	151914	154764
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009

Data are unavailable for 2008 and 2009. The provisional estimates are developed using a linear projection with data from 2000 through 2007.

Data were updated for 2007, 2008, and 2009.

Narrative:

In 2007, the rate of low birth weight in Georgia was approximately double the Healthy People 2010 objectives. The rate infants born weighting less than 2,500 grams increased by 10.5 percent between 1998 and 2007. Women who had more than a high school education had a lower rate of low birth weight than women with a high school degree or less. Rates of low birth weight were elevated among Black infants. The rate of low birth weight among Black infants was nearly three times the Healthy People 2010 objective. Hispanic infants had the lowest rate of low birth weight. Among Georgia's 18 public health districts, there were seven public health districts with rates of low birth weight in excess of 10.5 percent. Of these seven public health districts, four had rates of low birth weight in excess of 11.0 percent.

This indicator is used for surveillance and monitoring of poor birth outcomes in Georgia. The Office of Health Information and Policy (OHIP) has developed an online web tool for querying Vital Statistics and Hospital Discharge data. Low birth weight is one of the indicators contained within these data. The MCH Epidemiology Section produces the Reproductive Health Indicators Report that provides trend data by race/ethnicity, public health district and perinatal region to monitor key indicators of reproductive health, including low birth weight. In addition, the prevalence of low birth weight is calculated for geographical and population subgroups to provide information that is used to target resources and to develop interventions addressed at increasing birth weight. Low birth weight has also been used as an outcome in the evaluation of public health programs, including WIC, Medicaid Perinatal Case management, and Babies Born Healthy.

The Division of Medical Assistance has been leading an effort to understand the impact of strategies to reduce low birth weight on the rate of low birth weight. Included in the justification for the Family Planning Waiver submitted by the Division of Medical Assistance is to reduce subsequent poor birth outcomes including low birth weight.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	7.7	7.7	7.7	7.9	8.0
Numerator	10444	10444	11231	11553	11894
Denominator	136440	136440	145900	146445	149050
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009

Data are unavailable for 2008 and 2009. The provisional estimates are developed using a linear projection with data from 2000 through 2007.

Data were updated for 2007, 2008, and 2009.

Narrative:

Data from 2000 through 2007 indicate little change in the proportion of all low birth weight births attributed to multiple births. In this time period, the average percent of all low birth weight deliveries that were attributed to singleton births was 78.5 percent with a standard deviation of 0.3 percentage points.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance	2005	2006	2007	2008	2009
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Data					
Annual Indicator	1.8	1.8	1.8	1.8	1.8
Numerator	2563	2563	2780	2786	2852
Denominator	140903	140903	150804	151914	154764
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009

Data are unavailable for 2008 and 2009. The provisional estimates are developed using a linear projection with data from 2000 through 2007.

Data were updated for 2007, 2008, and 2009.

Narrative:

In 2007, the rate of very low birth weight in Georgia was approximately double the Healthy People 2010 objectives. Though double the Healthy People 2010 objective of 0.9 percent, the rate of infants born weighing less than 1,500 grams remained consistent from 1998 through 2007. Women who had more than a high school education had a lower rate of very low birth weight than women with a high school degree or less. The rate of very low birth weight was elevated among Black infants. The rate of very low birth weight among Black infants was nearly four times the Healthy People 2010 objective. Hispanic infants had the lowest rate of very low birth weight. Among Georgia's 18 public health districts, four had rates of very low birth weight in excess of 2.0 percent.

This indicator is used for surveillance and monitoring of poor birth outcomes in Georgia. The Office of Health Information and Policy (OHIP) has developed an online web tool for querying Vital Statistics and Hospital Discharge data. Very low birth weight is one of the indicators contained within these data. The MCH Epidemiology Section produces the Reproductive Health Indicators Report that provides trend data by race/ethnicity, public health district and perinatal region to monitor key indicators of reproductive health, including very low birth weight. In addition, the prevalence of very low birth weight is calculated for geographical and population subgroups to provide information that is used to target resources and to develop interventions addressed at increasing birth weight. In support of National Performance Measure 17, the MCH Epidemiology Section analyzes the level of care of hospitals where babies weighing less than 1,500 grams are born to monitor the effectiveness of the regional perinatal system in ensuring that all women are receiving the appropriate level of care.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	1.4	1.4	1.4	1.5	1.5
Numerator	1973	1973	2099	2132	2179
Denominator	136440	136440	145900	146445	149050

Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009

Data are unavailable for 2008 and 2009. The provisional estimates are developed using a linear projection with data from 2000 through 2007.

Data were updated for 2007, 2008, and 2009.

Narrative:

Data from 2000 through 2007 indicate little change in the proportion of all very low birth weight births attributed to multiple births. In this time period, the average percent of all very low birth weight deliveries that were attributed to singleton births was 77.3 percent with a standard deviation of 1.3 percentage points.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	9.0	9.0	6.2	6.3	6.0
Numerator	177	177	131	133	130
Denominator	1969278	1969278	2109362	2127815	2156790
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009

Georgia Final Death File, 2000-2007, accessed through OASIS. ICD-10 codes V02-V04, V09.0, V09.2, V12-V14, V19.0-V19.2, V19.4-V19.6, V20-V79, V80.3-V80.5, V81.0-V81.1, V82.0-V82.1, V83-V86, V87.0-V87.8, V88.0-V88.8, V89.0, V89.2, W00-W19, W32-W34, W65-W74, X00-X09, and X40-X49.

Injuries included: Motor Vehicle Crashes, Falls, Accidental Shooting, Drowning, Fire and Smoke Exposure, and Poisoning.

Data are unavailable for 2008 and 2009. The provisional estimates are developed using a linear projection with data from 2000 through 2007. Population data provided by the Georgia Online Analytic Statistical Information System. Population data for 2009 are estimated using a linear projection with data from 2000 through 2008.

Data were updated for 2007, 2008, 2009.

Narrative:

Among children 1 to 5 years of age, three of the top five causes of death were unintentional injuries. Among children 6 to 9 years of age, four of the top ten causes of death were unintentional injuries. Among children 10 to 14 years of age, three of the top ten causes of death were unintentional injuries. Among these causes of death alone, there was a total of 7,780.5 years of potential life lost.

This indicator is used for surveillance and monitoring of years of potential life lost in children due to injury. OHIP has developed an online web tool containing Vital Statistics and Hospital Discharge data. OASIS is a flexible tool that allows for querying of several variables including cause of death, cause of hospitalization, and age. Several MCH Program partners including the Injury Prevention Program and Georgia Poison Center contribute to efforts to reduce the unintentional injury mortality rate.

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	3.5	3.5	3.6	3.4	3.2
Numerator	69	69	75	73	70
Denominator	1969278	1969278	2109362	2127815	2156790
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009

Georgia Final Death File, 2000-2007, accessed through OASIS. ICD-10 codes V02-V04, V09.0, V09.2, V12-V14, V19.0-V19.2, V19.4-V19.6, V20-V79, V80.3-V80.5, V81.0-V81.1, V82.0-V82.1, V83-V86, V87.0-V87.8, V88.0-V88.8, V89.0, and V89.2 .

Consists of all accidents in which any motorized vehicle (car, truck, motorcycle, etc.) was involved, including ones involving motor vehicles injuring pedestrians or bicyclists.

Data are unavailable for 2008 and 2009. The provisional estimates are developed using a linear projection with data from 2000 through 2007. Population data provided by the Georgia Online Analytic Statistical Information System. Population data for 2009 are estimated using a linear projection with data from 2000 through 2008.

Data were updated for 2007, 2008, and 2009.

Narrative:

This indicator is used for surveillance and monitoring of years of potential life lost in children due to injury. Motor vehicle crashes are the leading cause of death among children ages 14 years and younger. In 2007, motor vehicle deaths result in 4,750 years of potential life lost. The MCH Program and its partners work to reduce motor vehicle crash mortality through education and by providing car safety seats to children in need throughout Georgia.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	27.0	27.0	31.7	30.9	30.9
Numerator	355	355	421	414	426
Denominator	1313523	1313523	1326310	1340902	1377079
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009

Georgia Final Death File, 2000-2007, accessed through OASIS. ICD-10 codes V02-V04, V09.0, V09.2, V12-V14, V19.0-V19.2, V19.4-V19.6, V20-V79, V80.3-V80.5, V81.0-V81.1, V82.0-V82.1, V83-V86, V87.0-V87.8, V88.0-V88.8, V89.0, and V89.2.

Consists of all accidents in which any motorized vehicle (car, truck, motorcycle, etc.) was involved, including ones involving motor vehicles injuring pedestrians or bicyclists.

Data are unavailable for 2008 and 2009. The provisional estimates are developed using a linear projection with data from 2000 through 2007. Population data provided by the Georgia Online Analytic Statistical Information System. Population data for 2009 are estimated using a linear projection with data from 2000 through 2008.

Data were updated for 2007, 2008, and 2009.

Narrative:

This indicator is used for surveillance and monitoring of years of potential life lost in children due to injury. Motor vehicle crashes are the leading cause of death among children/young adults between the ages of 15 to 24 years. In 2007, motor vehicle deaths result in 23,366 years of potential life lost. The MCH Program and its partners work to reduce motor vehicle crash mortality through education and policy initiatives to reduce the risk of motor vehicle crashes in this age group. Legislation enacted on July 1, 2010 that limits cell phone use for adolescent drivers and texting for all drivers may lead to a decrease in this indicator.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	149.1	149.1	3,741.7	3,856.6	3,850.4
Numerator	2937	2937	78925	82061	83045
Denominator	1969278	1969278	2109362	2127815	2156790
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009

Inpatient and ER discharges with E-codes E810-825, E880-888, E922, E910, E890-899, E850-869, and E924.1 for years 2002-2007. Data accessed through OASIS.

Injuries included: Motor Vehicle Crashes, Falls, Accidental Shooting, Drowning, Fire and Smoke Exposure, and Poisoning.

Data are unavailable for 2008 and 2009. The provisional estimates are developed using a linear projection with data from 2002 through 2007. Population data provided by the Georgia Online Analytic Statistical Information System. Population data for 2009 are estimated using a linear projection with data from 2000 through 2008.

Data were updated for 2007, 2008, and 2009.

Narrative:

Unintentional injuries including falls, accidental poisonings, and motor vehicle accidents are among the top ten leading causes of hospitalization and emergency room visits. This indicator is used for surveillance and monitoring of years of potential life lost in children due to injury. OHIP has developed an online web tool containing Vital Statistics and Hospital Discharge data. OASIS is a flexible tool that allows for querying of several variables including cause of hospitalization and age. Several MCH Program partners including the Injury Prevention Program and Georgia Poison Center contribute to efforts to reduce the unintentional injury morbidity rate.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	33.3	33.3	550.2	561.7	545.6
Numerator	655	655	11605	11952	11767
Denominator	1969278	1969278	2109362	2127815	2156790
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving					

average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009

Inpatient and ER discharges with E-codes E810-E825, 2002-2007. Data accessed through OASIS.

Consists of all accidents in which any motorized vehicle (car, truck, motorcycle, etc.) was involved, including ones involving motor vehicles injuring pedestrians or bicyclists.

Data are unavailable for 2008 and 2009. The provisional estimates are developed using a linear projection with data from 2002 through 2007. Population data provided by the Georgia Online Analytic Statistical Information System. Population data for 2009 are estimated using a linear projection with data from 2000 through 2008.

Data were updated for 2007, 2008, and 2009.

Narrative:

Motor vehicle crashes are among the top ten causes of emergency room visits and hospitalizations in Georgia among children 14 years of age and younger. In 2007, approximately 10,000 emergency room visits and 600 hospitalizations were attributed to motor vehicle crashes. The MCH Program and its partners work to reduce motor vehicle crash mortality through education and by providing car safety seats to children in need throughout Georgia.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	151.3	151.3	2,382.6	2,493.0	2,431.0
Numerator	1987	1987	31600	33429	33477
Denominator	1313523	1313523	1326310	1340902	1377079
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2009

Inpatient and ER discharges with E-codes E810-E825, 2002-2007. Data accessed through OASIS.

Consists of all accidents in which any motorized vehicle (car, truck, motorcycle, etc.) was involved, including ones involving motor vehicles injuring pedestrians or bicyclists.

Data are unavailable for 2008 and 2009. The provisional estimates are developed using a linear projection with data from 2002 through 2007. Population data provided by the Georgia Online Analytic Statistical Information System. Population data for 2009 are estimated using a linear projection with data from 2000 through 2008.

Data were updated for 2007, 2008, and 2009.

Narrative:

Among children ages 15 to 24 years, motor vehicle crashes are within the top two leading causes of hospitalizations and emergency room visits. In 2007, more than 20,000 emergency room visits and 1,500 hospitalizations were attributed to motor vehicle crashes. The MCH Program and its partners work to reduce motor vehicle crash morbidity through education and policy initiatives to reduce the risk of motor vehicle crashes in this age group. Legislation enacted on July 1, 2010 that limits cell phone use for adolescent drivers and texting for all drivers may lead to a decrease in this indicator.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	32.6	39.6	39.0	38.3	38.0
Numerator	10258	12438	12855	12762	12962
Denominator	314220	314220	329199	333417	340998
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009

STD Surveillance Program case reports, 2000-2008. Data accessed through OASIS.

The numerator consists of case reports. There is evidence that testing and/or reporting of STDs in Georgia may be selective, with some racial-ethnic groups disproportionately represented.

Data are unavailable for 2009. The provisional estimates are developed using a linear projection with data from 2000 through 2008. Population data provided by the Georgia Online Analytic Statistical Information System. Population data for 2009 are estimated using a linear projection with data from 2000 through 2008.

Data were updated for 2007, 2008, and 2009.

Notes - 2008

Note: 2007 data was revised as reported by Notifiable Disease.

Notes - 2007

The reported cases of Chlamydia is based on CY06 reports, while the denominator is based on 2006 population due to the lag in U.S. Bureau of Census Population estimates

Narrative:

Between 1999 and 2008, the rate of newly diagnosed cases of Chlamydia among adolescents exceeded 2,000 cases per 100,000 adolescents in every year except 2005. The greatest the rates of newly diagnosed cases of Chlamydia were found in 2007 and 2008. Comparing 1999 to

2008, the rate of newly diagnosed cases of Chlamydia among adolescents increased 14.6 percent. There were approximately double the numbers of newly diagnosed cases among adolescents 18 to 21 years of age as there were among adolescents 15 to 17 years of age. While adolescents 18 to 21 years of age account for the majority of newly diagnosed Chlamydia cases among adolescents, the rate of newly diagnosed cases of Chlamydia among adolescents 15 to 17 years of age exceeds 1,500 cases per 100,000 adolescents and the rate of newly diagnosed cases of gonorrhea exceeds 500 cases per 100,000 adolescents. Black adolescents had the greatest rates of newly diagnosed cases of Chlamydia. For the rates of newly diagnosed cases of Chlamydia, the ratio of rates among Black adolescents to White adolescents was ten to one. The ratio of rates among Black adolescents to Hispanic adolescents was seven to one for newly diagnosed cases of Chlamydia. Female adolescents had significantly greater rates of newly diagnosed cases of Chlamydia compared to male adolescents. The ratio of the rate of newly diagnosed cases of Chlamydia among female adolescents to male adolescents was four to one. There were four newly diagnosed cases of Chlamydia among adolescent females for every one newly diagnosed case among male adolescents.

This indicator is used for surveillance and monitoring of STDs and women's health. Chlamydia is a reportable disease and these data have been available on the Public Health website for several years. The OASIS web query tool includes STD data. Data can be queried by disease and age of the case. The STD Epidemiology Section conducts surveillance and produces reports on the prevalence and incidence of Chlamydia in Georgia.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	9.4	8.6	18.5	18.0	18.3
Numerator	18842	17657	32075	31275	32232
Denominator	2003939	2056786	1732819	1735509	1765089
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2009

STD Surveillance Program case reports, 2000-2008. Data accessed through OASIS.

The numerator consists of case reports. There is evidence that testing and/or reporting of STDs in Georgia may be selective, with some racial-ethnic groups disproportionately represented.

Data are unavailable for 2009. The provisional estimates are developed using a linear projection with data from 2000 through 2008. Population data provided by the Georgia Online Analytic Statistical Information System. Population data for 2009 are estimated using a linear projection with data from 2000 through 2008.

Data were updated for 2007, 2008, and 2009.

Notes - 2007

The reported cases of Chlamydia is based on CY06 reports, while the denominator is based on 2006 population due to the lag in U.S. Bureau of Census Population estimates

Narrative:

Between 1999 and 2008, the rate of newly diagnosed Chlamydia cases for women 18 to 44 years of age increased in all but three years. During this ten-year period, there was a 23 percent increase in the rate of newly diagnosed Chlamydia cases. Rates of newly diagnosed cases of Chlamydia were greatest among younger women and Black women. The ratio of the newly diagnosed case rate among women 18 to 19 years of age and 25 to 34 years of age was six to one. The newly diagnosed case rate ratio was four to one when comparing women ages 20 to 24 years of age to women 25 to 34 years of age. Black women have the greatest rates of newly diagnosed cases of Chlamydia. For rates of newly diagnosed cases of Chlamydia, the newly diagnosed case rate ratio of Black women to White women was nine to one and fifteen to one. The newly diagnosed case rate ratio of Black women to Hispanic women was four to one for Chlamydia. Among Georgia's 18 public health districts, the Southwest Health District and the West Central Health District had the greatest rates of newly diagnosed cases of Chlamydia. These were the only two public health districts with rates of newly diagnosed cases of Chlamydia in excess of 2,000 cases per 100,000 women 18 to 44 years of age. There were eight other public health districts with rates of newly diagnosed cases of Chlamydia in excess of 1,500 cases per 100,000 women 18 to 44 years of age.

This indicator is used for surveillance and monitoring of STDs and women's health. Chlamydia is a reportable disease and these data have been available on the Public Health website for several years. The OASIS web query tool includes STD data. Data can be queried by disease and age of the case. The STD Epidemiology Section conducts surveillance and produces reports on the prevalence and incidence of Chlamydia in Georgia.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Infants 0 to 1	153738	95728	47308	897	4363	202	5240	0
Children 1 through 4	586783	361074	187850	2583	17642	688	16946	0
Children 5 through 9	711353	443635	223948	3090	20060	927	19693	0
Children 10 through 14	675941	408551	231761	2400	18353	663	14213	0
Children 15 through 19	687846	406482	251483	2442	16201	581	10657	0
Children 20 through 24	653056	396993	229736	2500	14982	635	8210	0
Children 0 through 24	3468717	2112463	1172086	13912	91601	3696	74959	0

Notes - 2011

Narrative:

The race of nearly 95 percent of all children in Georgia is either White or Black/African American. The ratio of White to Black/African American children in Georgia is 1.8 to 1. This indicator is used to monitor population trends to understand demographic changes in Georgia and best target resources.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Infants 0 to 1	125443	28295	0
Children 1 through 4	495826	90957	0
Children 5 through 9	623945	87408	0
Children 10 through 14	615809	60132	0
Children 15 through 19	637994	49852	0
Children 20 through 24	599702	53354	0
Children 0 through 24	3098719	369998	0

Notes - 2011**Narrative:**

Among children under the age of 10 years, 14.2 percent are Hispanic or Latino compared to 8.1 percent among children between the ages of 10 and 24 years. Nearly one-fifth of all infants born in Georgia are Hispanic or Latino. This indicator is used to monitor population trends to understand demographic changes in Georgia and best target resources.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Women < 15	293	96	189	1	2	0	5	0
Women 15 through 17	5756	2801	2782	15	32	6	120	0
Women 18 through 19	12287	6377	5490	24	104	12	280	0
Women 20 through 34	113365	68296	37468	297	4236	137	2931	0
Women 35 or older	19103	12152	5219	40	1131	17	544	0
Women of all ages	150804	89722	51148	377	5505	172	3880	0

Notes - 2011

Narrative:

Births to women under the age of 20 years accounted for a greater proportion of births to Black/African American (16.5 percent) women than White women (10.3 percent). Women age 35 years and older accounted for a greater percent of births to White women than Black/African American women. This indicator is used to monitor the trends in births and understand demographic changes in Georgia and best target resources.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Women < 15	234	50	9
Women 15 through 17	4599	1065	92
Women 18 through 19	10179	1860	248
Women 20 through 34	92406	19168	1791
Women 35 or older	16477	2332	294
Women of all ages	123895	24475	2434

Notes - 2011**Narrative:**

The distribution of maternal age by ethnicity is similar between Hispanic and non-Hispanic women. Births to women 35 years and older accounted for a greater percent of all births among Hispanic women compared to non-Hispanic women, but the percent of all births attributed to women age 20 years and older was identical between the groups. This indicator is used to monitor the trends in births and understand demographic changes in Georgia and best target resources.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Infants 0 to 1	1198	524	654	3	15	2	0	0
Children 1 through 4	196	101	87	1	4	0	3	0
Children 5 through 9	103	60	42	0	1	0	0	0
Children 10 through 14	116	59	51	0	5	0	1	0
Children 15 through 19	516	300	207	2	6	0	1	0
Children 20	757	467	281	0	8	1	0	0

through 24								
Children 0 through 24	2886	1511	1322	6	39	3	5	0

Notes - 2011

Narrative:

While the ratio of the number of White children to Black/African American children is 1.8 to 1, the ratio for child death is 1.1 to 1. This indicates that Black/African American children are overrepresented in the mortality data compared to the population. This indicator is used to monitor the burden of death in children and variation by subpopulations to target resources. MCH Epidemiology conducts analyses of infant deaths to identify groups at highest risk and to identify risk factors that may be potentially modifiable. Results from these analyses are being used to target intervention efforts and to focus efforts on effective interventions.

Health Status Indicators 08B: Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)

HSI #08B - Demographics (Total deaths)

CATEGORY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Total deaths			
Infants 0 to 1	1119	75	4
Children 1 through 4	182	14	0
Children 5 through 9	95	7	1
Children 10 through 14	110	6	0
Children 15 through 19	482	30	4
Children 20 through 24	698	56	3
Children 0 through 24	2686	188	12

Notes - 2011

Narrative:

The distribution of childhood mortality by age is similar between Hispanic and non-Hispanic children. This indicator is used to monitor the burden of death in children and variation by subpopulations to target resources. MCH Epidemiology conducts analyses of infant deaths to identify groups at highest risk and to identify risk factors that may be potentially modifiable. Results from these analyses are being used to target intervention efforts and to focus efforts on effective interventions.

Health Status Indicators 09A: Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown	Specific Reporting Year
Misc Data BY RACE									

All children 0 through 19	2815661	1715470	942350	11412	76619	3061	66749	0	2008
Percent in household headed by single parent	35.0	12.0	20.0	0.0	0.0	0.0	1.0	2.0	2008
Percent in TANF (Grant) families	1.3	0.6	2.8	0.0	0.1	0.0	0.0	0.0	2008
Number enrolled in Medicaid	1076130	453229	542001	773	13064	977	3	66083	2008
Number enrolled in SCHIP	272378	134864	97841	112	11639	36	3	27883	2008
Number living in foster home care	2774	1353	1075	69	35	0	173	69	2007
Number enrolled in food stamp program	528565	188221	335583	432	3634	695	0	0	2007
Number enrolled in WIC	348658	103140	135889	2428	66361	7906	5641	27293	2008
Rate (per 100,000) of juvenile crime arrests	1744.0	1368.0	2872.0	0.0	0.0	0.0	0.0	0.0	2008
Percentage of high school drop-outs (grade 9 through 12)	3.8	3.2	4.7	2.0	1.6	0.0	3.9	0.0	2008

Notes - 2011

Georgia population data, accessed through OASIS.

<http://oasis.state.ga.us/oasis/qryPopulation.aspx>. See Note for HSI 6-7.

Data from Table S0901, 2008 American Community Survey.

From Table 35. <http://www.acf.hhs.gov/programs/ofa/character/FY2008/tab35.htm>. The percentage for Other/Unknown is zero because while the numerator data source includes Other/Unknown, the denominator data source is 0. Race and ethnicity are reported under one measure in this data system.

Georgia Medicaid program data. Race and ethnicity are reported under one measure in the data system. Hispanic enrollees (44,728 in CHIP and 5,012 in Medicaid) are included in the total but not in the race breakdown.

Georgia Medicaid program data. Race and ethnicity are reported under one measure in the data system. Hispanic enrollees (44,728 in CHIP and 5,012 in Medicaid) are included in the total but not in the race breakdown.

Using Race and Age Tables from <http://www.dfcsdata.dhr.state.ga.us/menusearch06.asp>, the total participants in the food stamp program were calculated. To get the number 18-19 the count

of 18-21 was divided by two and added to those <18. Race distributions for participants in the food stamp program were then applied to this count to get race specific counts.

Georgia WIC program data. Includes infants and children 0-5 and prenatal, breastfeeding, and non-breastfeeding women 11-19 served by WIC.

Georgia Department of Juvenile Justice (DJJ) data: Number of intake admissions. Data accessed at <http://www.djj.state.ga.us/Statistics/rptstatDescriptive.asp?type=State>. The percentage for Other/Unknown is zero because while the numerator data source includes Other/Unknown, the denominator data source is zero. American Indian/Native Alaskan, Asian, Native Hawaiian/Other Pacific Islander, and Multiracial are zero because these are not reported by DJJ. Race and ethnicity were reported under one measure in this data system. Counts are limited to those <18.

Data from the Georgia Department of Education (school year), and accessed at www.gadoe.org/ReportingFW.aspx?PageReq=1023&StateId=ALL&T=1. Race and ethnicity are reported under one measure in this data system.

Race and ethnic breakdown of the data were not available, so the national distribution, from the FFY2008 aFCARS report were applied to the Georgia total count.

http://www.acf.hhs.gov/programs/cb/stats_research/afcars/tar/report16.htm. Race and ethnicity were reported under one measure in the data system.

Narrative:

Black/African American children are overrepresented in public programs based on the population distribution. The percent of Black/African children who did not complete high school and the rate of juvenile crime arrests among this population of children are greater than among White children. Understanding shifts in utilization of public programs for MCH populations is useful in determining other MCH programmatic needs and the effect on MCH health status.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity.* (Demographics)

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported	Specific Reporting Year
Miscellaneous Data BY HISPANIC ETHNICITY				
All children 0 through 19	2499017	316644	0	2008
Percent in household headed by single parent	31.4	3.4	0.0	2008
Percent in TANF (Grant) families	1.4	0.4	0.0	2008
Number enrolled in Medicaid	1010047	5012	66083	2008
Number enrolled in SCHIP	244493	44728	27883	2008
Number living in foster home care	2706	694	69	2007
Number enrolled in food stamp program	500616	27950	0	2007
Number enrolled in WIC	270558	78094	6	2008
Rate (per 100,000) of juvenile crime arrests	1824.0	887.0	0.0	2008
Percentage of high school drop-outs (grade 9 through 12)	3.8	4.2	0.0	2008

Notes - 2011

Georgia population data, accessed through OASIS.
<http://oasis.state.ga.us/oasis/qryPopulation.aspx>. See Note for HSI 6-7.

From Table S0901, 2008 American Community Survey.

From Table 35. <http://www.acf.hhs.gov/programs/ofa/character/FY2008/tab35.htm>. The percentage for Other/Unknown is zero because while the numerator data source includes Other/Unknown, the denominator data source was zero. Race and ethnicity were reported under one measure in this data system.

Georgia Medicaid program data. Race and ethnicity are reported under one measure in the data system. Hispanic enrollees (44,728 in CHIP and 5,012 in Medicaid) are included in the total but not in the race breakdown.

Georgia Medicaid program data. Race and ethnicity are reported under one measure in the data system. Hispanic enrollees (44,728 in CHIP and 5,012 in Medicaid) are included in the total but not in the race breakdown.

Using Race and Age Tables from <http://www.dfcsdata.dhr.state.ga.us/menusearch06.asp>, the total participants in the food stamp program were calculated. To get the number 18-19 the count of 18-21 was divided by two and added to those <18. Ethnic distributions for participants in the food stamp program were then applied to this count to get ethnicity specific counts.

Georgia WIC program data. Includes infants and children 0-5 and prenatal, breastfeeding, and non-breastfeeding women 11-19 served by WIC.

Georgia Department of Juvenile Justice (DJJ) data: Number of intake admissions. Data accessed at <http://www.djj.state.ga.us/Statistics/rptstatDescriptive.asp?type=State>. The percentage for Other/Unknown is zero because while the numerator data source includes Other/Unknown, the denominator data source is zero. American Indian/Native Alaskan, Asian, Native Hawaiian/Other Pacific Islander, and Multiracial are zero because these were not reported by DJJ. Race and ethnicity were reported under one measure in this data system.

Data from the Georgia Department of Education (school year), and accessed at www.gadoe.org/ReportingFW.aspx?PageReq=1023&StateId=ALL&T=1. Race and ethnicity were reported under one measure in this data system.

Race and ethnic breakdown of the data was not available, and so the national distribution, from the FFY2008 aFCARS report were applied to the Georgia total count.

http://www.acf.hhs.gov/programs/cb/stats_research/afcars/tar/report16.htm. Race and ethnicity are reported under one measure in the data system.

Narrative:

Less than 5 percent of Hispanic children report being in a household headed by a single parent compared to more than 30 percent among non-Hispanic children. Participation data for Medicaid and SCHIP are difficult to interpret given the large number participants with unknown ethnicity. While the percent of Hispanic children who do not complete high school is greater than among non-Hispanic children, the rate of juvenile crime arrests among non-Hispanic children is double that of Hispanic children.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	930328
Living in urban areas	2344537
Living in rural areas	471124
Living in frontier areas	0
Total - all children 0 through 19	2815661

Notes - 2011

Narrative:

Georgia has undergone a shift from a largely rural state with urban clusters to a primarily urban state with rural areas. During the previous 25 years, Georgia has been described in terms to "two Georgias" -- economically strong urban and less economically advantaged rural. However, over the previous decade, the state's population has become segmented into four distinct groupings among Georgia's 159 counties. These are:

- Urban -- 14 counties that form the core centers for Georgia's 15 metropolitan statistical areas (MSAs)
- Suburban -- 56 counties located in the 15 Georgia MSAs
- Rural growth -- 30 rural counties with small core urban areas that serve as a stimulus for supporting the local economy
- Rural decline -- 30 counties, almost all located in south Georgia, experiencing population declines

Monitoring of shifts in population in rural and urban areas is helpful in targeting MCH programs and planning interventions and strategy.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	9418066.0
Percent Below: 50% of poverty	6.2
100% of poverty	14.7
200% of poverty	33.8

Notes - 2011

Narrative:

Childhood poverty is an important indicator of child health and MCH programmatic needs. Monitoring child poverty allows the MCH Program to determine possible demand for services.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	2572848.0
Percent Below: 50% of poverty	8.6

100% of poverty	20.2
200% of poverty	43.3

Notes - 2011

Narrative:

Childhood poverty is an important indicator of child health and MCH programmatic needs. Monitoring child poverty allows the MCH Program to determine possible demand for services.

F. Other Program Activities

Toll-free Hotlines: Georgia's Title V toll-free hotline, PowerLine, is run by Healthy Mothers, Healthy Babies Coalition of Georgia (HMHB) under a MCH contract. PowerLine assists women, pregnant women, parents, health care providers, social service agencies, community organizations, and any other individual or agency experiencing difficulties in obtaining information about health care and/or health care services. The bilingual toll-free number (statewide 1-800-822-2539; Metro Atlanta 770-481-5501) is available Monday-Friday 8:00 A.M. through 6:00 P.M., staffed with Information and Referral Specialists that provide callers with information on local general practitioners and medical specialists; dentists; prenatal healthcare services; low cost healthcare resources for the uninsured; HIV testing sites; dental, vision, and hearing screening facilities; breastfeeding information resources; plus other healthcare and public health referrals. PowerLine also answers the Georgia WIC customer service toll-free telephone line, referring callers to the appropriate WIC Clinic and recording complaints or fraud reports. In addition, PowerLine provides referrals for DPH's Perinatal HIV Prevention Project, Women's Health, Newborn Screening, Babies Can't Wait, Women's Right to Know, PeachCare for Kids, and Children 1st. The PowerLine maintains Georgia's most comprehensive database of physicians and clinics that accept Medicaid and PeachCare, reduced fees, and/or low cost fees. The database also houses a number of free clinics and providers. Each fiscal year, PowerLine assists over 25,000 individuals experiencing difficulties or delays in accessing healthcare services, providing over 50,000 referrals to services.

Babies Can't Wait (Part C, IDEA) supports a separate toll-free number (1-800-229-2038) for individuals with disabilities, families of children with special needs, and professionals that provides a special needs database/directory of over 5,000 public and private early intervention services, research and demonstration projects, professional groups, parent support groups and advocate associations available in the state for children with or at-risk for developmental delays or disabilities. There are over 150 searchable categories, including advocacy, early intervention, diagnostic and evaluation, physical therapy, speech therapy, occupational therapy, child care centers, respite care, Medicaid, education, counseling, support groups, camps, vocational services, and many others. A unique hotline feature is that a parent of a child with a disability answers the phone. This BCW central directory is operated by Parent to Parent of Georgia, a statewide parent-run organization.

In addition to obtaining information about services, hotline callers can be matched with supporting parents whose children have similar disabilities. The Parent to Parent of Georgia website also allows users to search the special needs database online (<http://p2pga.org>). Other website content includes a parent designed and created graphic roadmap to services that walks parents through what they need to know to navigate Georgia's disability, health, and education systems; information on reading materials, free health and education training courses, and family leadership and community opportunities; and a parent blog. Users can also sign up for an email list on healthcare and education, FaceBook updates, and twitter notices and news.

The toll-free Georgia Tobacco Quit Line (1-877-270-7867), funded by the tobacco Master

Settlement Agreement and implemented through DPH in collaboration with the Georgia Cancer Coalition, connects callers 13 years of age or older to a trained counselor who can help them develop a personal plan to stop smoking. The Quit Line is also available to the parents of youth who use tobacco products. Trained counselors offer counseling tailored to the caller's needs, self-help materials, and referral to other resources. The Quit Line is available 8:00 A.M. to 3:00 A.M. daily. A line (1-877-266-3863) is dedicated for Spanish-speaking callers.

The Georgia Crisis and Access Line (GCAL) serves as the central access point to connect the state's youth and adults to local services for mental health and addictive diseases services. Individuals can call the hotline (1-800-715-4225) 24 hours/seven days a week and be connected to clinical staff that assist callers with information and brief screening and evaluation services. In addition, a website (www.mygcal.com) offers users a list of Department of Behavioral Health and Developmental Disabilities providers and services by county.

Internet Resources: In 2008, DCH launched georgiahealthinfo.gov, a consumer-focused, one-stop resource for information on health education, health care providers, health care facilities, and health care comparison/planning information in Georgia. Website content includes health education materials, wellness and prevention information, local health care provider profiles, quality and cost comparison data, a long-term care decision support tool, and health plan comparison. georgiahealthinfo.gov is now available on twitter (gahi.gov) and Facebook.

MCH's Early Childhood Comprehensive Systems (ECCS) initiative is developing an online early childhood clearinghouse for consumers, child care providers, health care providers, early childhood advocates, and others. Clearinghouse resources are grouped in seven main information categories (child development, children with special needs, community advocacy and policy, early learning and child care, family support, health and dental care, and parenting information). The clearinghouse (www.eccsga.org) is live and currently includes summaries and links to over 400 early childhood web-based resources.

Other Activities: Outside of Title V funded activities, there are a number of other program activities comprising the MCH system that significantly impact the state's Title V population. These programs include Health Check (EPSDT), Right from the Start Medicaid, Family Planning, and Immunization, as well as activities focused on CSHCN, such as the Governor's Council on Developmental Disabilities and Social Security determination. The relationship between the MCH program and these activities is described in III. State Overview, Sections C (Organizational Structure) and D (Other Capacity) of this application. Family leadership and support activities are discussed in Section D.

G. Technical Assistance

The MCH Services Block Grant and Medicaid, known as Title V and Title XIX respectively, were created by the Social Security Act and are mandated to collaborate by a 1989 amendment to the act. Together these programs ensure that low-income families receive the health services they need. Georgia Title V seeks technical assistance to enhance the current relationship between Title V and Title XIX. Through the development of the FY11 Title V MCH Services Block Grant application, Medicaid was a topic of several public comments. These comments ranged from the selection of a care management organization and coordination of services for children with special health care needs through a medical home to the role that improved collaboration could have in treating obesity or supporting breastfeeding. One of Georgia's top priority needs also addresses the provider supply available through Medicaid to treat children with special health care needs. While the Division of Public Health and the Division of Medical Assistance are confronting significant funding challenges, a possible solution may lie in improved coordination, consolidation, and support of priorities shared by Title V and Title XIX.

The most recent agreement between Title V and Title XIX was effective July 1, 2003. This

agreement was developed when Title V and Title XIX were in different state agencies. Following the reorganization of the Division of Public Health, Title V and Title XIX are now co-located in the Department of Community Health. With changes in leadership in the Divisions of Medical Assistance and Public Health and the MCH Program, there is an opportunity to review the previous agreement and develop and implement an updated agreement. To develop and implement an updated agreement, each program must understand the limitations and priorities of the other to reach a consensus of what can be done to ensure optimal service for the Georgia MCH population. In addition to an updated agreement, improved understanding of the intersection between MCH programs, for example, WIC, Children's Medical Services, and Babies Can't Wait, and Medicaid is needed to ensure that Georgia maximizes each funding source. Another area of needed collaboration between the MCH Program and Medicaid will be the implementation of a planned Medicaid Women's Health Waiver. Given the funding for family planning in Georgia, successful implementation of this waiver will require coordination between Titles V, X, XIX, and XX.

Form 15 reflects the desire of Georgia Title V to work with an outside contractor that can identify education needs about each program and implement necessary training and/or prepare and distribute necessary documents and serve as an intermediary through the development of an updated agreement.

Given the many intersection points between Medicaid and Title V as well as other MCH Programs including WIC, Babies Can't Wait, and the Family Planning program, strengthening the partnership between Titles V and XIX is vital to the health of maternal and child health populations throughout Georgia. While Georgia may have other technical assistance needs, this is the only technical assistance need requested in the FY11 application to ensure that this need will be a priority and focal point for the upcoming year.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2009		FY 2010		FY 2011	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
1. Federal Allocation (Line1, Form 2)	17163380	16284772	16465518		16284772	
2. Unobligated Balance (Line2, Form 2)	0	0	0		0	
3. State Funds (Line3, Form 2)	142538442	116959469	134371463		131621290	
4. Local MCH Funds (Line4, Form 2)	0	0	0		0	
5. Other Funds (Line5, Form 2)	192238071	183375866	187239849		190934182	
6. Program Income (Line6, Form 2)	18316838	18316838	18316838		18316838	
7. Subtotal	370256731	334936945	356393668		357157082	
8. Other Federal Funds (Line10, Form 2)	271996222	270258475	279042341		310052058	
9. Total (Line11, Form 2)	642252953	605195420	635436009		667209140	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2009		FY 2010		FY 2011	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Federal-State MCH Block Grant Partnership						
a. Pregnant Women	20654708	16330729	19695259		19706599	
b. Infants < 1 year old	88200480	79928330	87569920		84975620	

c. Children 1 to 22 years old	206889815	191181361	199505526		202943636	
d. Children with Special Healthcare Needs	35210145	28195473	26442677		26860677	
e. Others	17895604	17357752	21383482		21108167	
f. Administration	1405979	1943300	1796804		1562383	
g. SUBTOTAL	370256731	334936945	356393668		357157082	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	100000		100000		100000	
c. CISS	140000		140000		140000	
d. Abstinence Education	0		0		0	
e. Healthy Start	3000000		3000000		3000000	
f. EMSC	150000		150000		150000	
g. WIC	252567436		259751438		274633624	
h. AIDS	0		0		0	
i. CDC	1807829		1165607		1367647	
j. Education	14087196		14735296		14735296	
k. Other						
ARRA	0		0		15925491	
UNHS	143761		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2009		FY 2010		FY 2011	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Direct Health Care Services	139330661	130077501	137697259		136503059	
II. Enabling Services	29843278	23212424	26492146		25309693	
III. Population-Based Services	174937215	157306736	165887769		169928716	
IV. Infrastructure Building Services	26145577	24340284	26316494		25415614	
V. Federal-State Title V Block Grant Partnership Total	370256731	334936945	356393668		357157082	

A. Expenditures

A. EXPENDITURES

State and federal funds are allocated based on priority needs identified through the MCHBG

development process. This process includes reviewing health status and outcomes for women and children, projecting future needs and assessing current capacity/infrastructure. The MCH Program, in concert with the Division of Public Health, makes recommendations for funding levels for services to women and children. These funding requests are then processed through the Georgia General Assembly's Annual Appropriations Bill.

The state required match on our FFY 2009 MCHBG Budget of \$16,284,772 is \$12,213,579. Using Georgia's Office of Financial Services MCH Block Grant Expenditure Report, the FFY 2009 state match is \$23,985,650 (as of 6/15/09). Georgia's maintenance of effort (MOE) level is \$36,079,622. Our current MOE level is \$42,848,260 for the FFY 2009 grant as of 6/15/09.

B. Budget

The Department of Community Health has a system of accountability to monitor the allocation and expenditures of funds provided to local health districts. The department utilizes the computer program, Uniform Accounting System (UAS), where the local health districts' administrative personnel input budget (funds that are allocated by programs such as Children with Special Health Care Needs) and expenditures. The Office of Planning and Budget Services approves all allocations to the local health districts. Reconciliations are made on a quarterly basis. In addition to the department staff, staff the MCH Program and Division of Public Health monitor programs quarterly and provide technical assistance where needed.

The FFY 2011 Budget for the Federal-State block grant partnership totals \$357,157,082. Of this amount, \$16,284,772 is Title V funds. The remaining amounts represent State Funds totaling \$131,621,290 and \$190,934,182 in Other Funds, and \$18,316,838 in Program Income. Other Federal funds that support Maternal and Child Health (MCH) activities in Georgia are estimated at \$310,052,058. This represents a variety of Federal Programs including three (3) Healthy Start Projects; Emergency Medical Services for Children (EMSC); Women, Infants, and Children (WIC), State Systems Development Initiative (SSDI), Universal Hearing Screening, and Healthy Child Care 2000. This brings the grand total for the State MCH Budget to \$667,209,140 (see line 11 of Form 2).

For FFY 2011, \$136,503,059 is budgeted for Direct Medical Care Services, \$25,309,693 for Enabling Services, \$169,928,716 for Population-Based Services, and \$25,415,614 for Infrastructure Building Services.

The total Federal-State Block Grant Partnership for FFY 2011 includes approximately \$18,316,838 in Program Income (See Form 2, line 6). This income is derived from Medicaid earnings for services provided to pregnant and post partum women, preventive health care services to children, and reproductive health services to women.

Of the Title V requested allocation (\$16,284,772), \$7,814,816 or 47.99% is earmarked for preventive and primary care for children. Infants less than one year old - The block grant funds (\$252,896) are used to support the positions and administration of High Risk Infant Follow-up - home visits for medically fragile infants and newborns. Title V-leveraged services for this population include: Pregnancy Related Services - Medicaid post partum home and clinic visits through 1st year of life, Neonatal Intensive Care Unit (NICU) Benefits and Administration - 6 tertiary centers statewide which provide clinical care and education services for high risk newborns, education to prevent Sudden Infant Death Syndrome (SIDS), single point of entry - Children 1st, MCH Drugs, and staffing for Local Health Districts; Children 1-22 years old: Title V funds (\$7,561,920) are used in this area for, Lead Based Poisoning, Oral Health (contract with Richmond County Board of Health to provide dental services to mothers, infants, and children in the Augusta health district and to provide training opportunities for pediatric dental residents in a mobile clinic environment), and Vaccines for Children. The Title V-leveraged services for this population include EPSDT Health Check - quality assurance, Children 1st, Family Connection -

help partners strengthen families in Georgia by building their capacity to develop relationships and implement community-driven plans, linking community priorities and efforts to state decision makers and promote "what works" using research and evaluation, and connecting partners to each other and to the statewide network of 159 Family Connection county collaborative, and the MATCH Program - a system that supports services for children with severe behavior and/or health problems. Approximately 45.36% or (\$7,386,969), is earmarked for Children with Special Health Care Needs to support Genetic/Sickle, Children Medical Services and Pediatric AIDS. There is 4.29% or \$699,732, earmarked for Title V administrative costs, used to support positions and administration. These positions provide data, quality assurance, technical assistance, policy, planning, and operational services that support and enhance the State's MCH system. These percentages are in keeping with the 30/30 required by Title V. The remaining \$383,255 is used to support comprehensive health services for (pregnant) women. The Title V leveraged services are: Babies Born Healthy - prenatal care for uninsured low income, six Tertiary Care Centers - high risk maternal services, and MCH Drugs.

We do not anticipate any budget issues relative to MCH Block Grant Match requirements for the FFY 2011 budget.

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

For the detail sheets and objectives for the state performance measures developed from the 2010 needs assessment, refer to TVIS Forms, Form 11 and Form 16 under the section "New State Performance Measure Detail Sheets and Data."

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.